MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16296

CERTIFICATE OF DEATH

16287

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. **PLACE OF DEATH**
   a. COUNTY: Anne Arundel — MARYLAND
   b. CITY OR TOWN (If outside corparate limits, write RURAL and give nearest tawn): Millersville
   c. LENGTH OF STAY IN 1b: 8 Days
   d. NAME OF HOSPITAL OR INSTITUTION (If nat in hospital, give street address): Knollwood Manor N/Home

2. **USUAL RESIDENCE** (Where deceased lived, if institutian: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Anne Arundel
   c. CITY OR TOWN (If outside corparate limits, write RURAL and give nearest tawn): Millersville 021
   d. STREET ADDRESS: Box #151 Rt. #2
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. **NAME OF DECEASED** (Type or print): First Mr. James Middle Albert Last
4. **DATE OF DEATH**: Manth Dec. Day 22 Year 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: April 24, 1882
9. AGE (In years last birthday): 85 yrs.
IF UNDER 1 YEAR: Manths / Days — IF UNDER 24 HRS.: Haurs / Min.

10a. USUAL OCCUPATION (Give kind af wark dane during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: Bricklayer
11. BIRTHPLACE (County & State, or fareign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: (unknown) Portaskiewicz
14. MOTHER'S MAIDEN NAME: (unknown)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na, or unknown): No
(If yes give war or dates of service): None
16. SOCIAL SECURITY NO.: 216/05/6510
17. INFORMANT: Steven Albert (Son) — Address: Same As # 2

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter anly ane cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(b): Myocardial infarction — 1 day
DUE TO
(c): Arteriosclerotic Cardiovascular disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature af injury in Part I ar Part II at item 18.)
20c. TIME OF INJURY Manth, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at wark ☐ Not While at wark ☐
20e. PLACE OF INJURY (Home, farm, factary, street, affice bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Jan 28, 1964, to Dec 22, 1967, that (I) (~~we~~) last saw the deceased alive an Dec 22 1967, and that death occurred at 1:30 P M, from causes and an the date stated abave.

22a. SIGNATURE: Ray M Smith — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Dec. 23 1967
22c. PHYSICIAN'S NAME (Type): Ray M. Smith MD
22d. ADDRESS: Hahn Professional Bldg., Severna Park, M

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Dec.26,67
23c. NAME OF CEMETERY OR CREMATORY: Our Lady of the Field
23d. LOCATION (City ar Tawn) (Cauntry) (State): Millersville, A.A. Md.

24. FUNERAL DIRECTOR: R.P. Ware — ADDRESS: Singleton Funeral Home, Glen Burnie, Md.
25a. REC'D BY REGISTRAR DATE: DEC 27 1967
25b. REGISTRAR'S SIGNATURE: J Charles Jones

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16297

CERTIFICATE OF DEATH

16288

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b: 30 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 316 - 5th Ave. S/E

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
d. STREET ADDRESS: 316 - 5th Ave/ S/E
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: CLARENCE; Middle: OSMAN; Last: ALLEN

4. DATE OF DEATH: Month: Dec.; Doy: 8,; Year: 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 10 May 1900

9. AGE (In years last birthday): 67 yrs.

IF UNDER 1 YEAR: Months; Doys — IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Auto Salesman (ret)

10b. KIND OF BUSINESS OR INDUSTRY: Park Circle

11. BIRTHPLACE (County & State, or foreign country): Severn, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Henry E. Allen

14. MOTHER'S MAIDEN NAME: Annie C. Griffith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service): ----------

16. SOCIAL SECURITY NO.: 217-01-9240

17. INFORMANT: Address: Mrs. Blanche M. Allen- Wife

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Congestive Heart Failu
DUE TO
(b): Severe Atherosclerotic Heart Disea
DUE TO
(c):
4200
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 1 day

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (~~this hospital~~) attended the deceased from 11-21, 1967, to 12-8, 1967, that (I) (~~we~~) last saw the deceased alive on 12/8 1967, and that death occurred at 5:42 P.M., from causes and on the date stated above.

22a. SIGNATURE: Wayne B. Tate M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 12/9/67

22c. PHYSICIAN'S NAME (Type): Wayne B. Tate

22d. ADDRESS: Central Ave. Glen Burnie, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 12/11/67

23c. NAME OF CEMETERY OR CREMATORY: Glen Haven Memorial Pk.

23d. LOCATION (City or Town) (County) (State): Glen Burnie, Md.

24. FUNERAL DIRECTOR: Singleton Funeral Home/Glen Burnie, Md.

ADDRESS

25a. REC'D BY REGISTRAR DATE: DEC 11 1967

25b. REGISTRAR'S SIGNATURE: Richard Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16298

CERTIFICATE OF DEATH

16289

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 10 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL - Annapolis
d. STREET ADDRESS: Rt-5, Box-181
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Homer — Middle: — Last: ANDERSON

4. DATE OF DEATH: Month: December — Day: 20 — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED XX DIVORCED ☐

8. DATE OF BIRTH: Jan. 25, 1886

9. AGE (In years last birthday): 81 yrs.

IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Delaware

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: William Anderson

14. MOTHER'S MAIDEN NAME: Sally (Compton (Howard))

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Eugene Anderson — Address: Annapolis Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Gen Debility + Senility — INTERVAL BETWEEN ONSET AND DEATH
4500
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Gen Arterio + Fr left Hip.
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES XX NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~this~~ hospital) attended the deceased from June 1967, 19____, to Dec. 20, 1967, that (I) (~~XX~~) last saw the deceased alive on Dec. 20 1967, and that death occurred at 4:20 AM, from causes and on the date stated above.

22a. SIGNATURE: Robert R Hahn — M.D. ATTENDING PHYS. XX — MED. DIRECTOR ☐ — STAFF PHYS. ☐

22b. DATE SIGNED: 12-20-67

22c. PHYSICIAN'S NAME (Type): Robert R. HAHN.

22d. ADDRESS: P.O. Box 73 Severna Park Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Dec 22, 1967

23c. NAME OF CEMETERY OR CREMATORY: Od Fellows Cem

23d. LOCATION (City or Town) (County) (State): Camden Md

24. FUNERAL DIRECTOR: J Harvey Williamson — ADDRESS: Federalsburg Md

25a. REC'D BY REGISTRAR DATE: DEC 27 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

16299

CERTIFICATE OF DEATH

16290

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers — Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: Anne Arundel — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Friendship
   c. LENGTH OF STAY IN 1b: 30 years
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): —

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: Md. — b. COUNTY: A. A.
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Friendship
   d. STREET ADDRESS: Route #778
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Bess — Middle: — Last: Armiger

4. DATE OF DEATH: Month: December — Day: 2 — Year: 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Nov. 2, 1889

9. AGE (In years last birthday): 78 yrs.
   IF UNDER 1 YEAR: Months — Days
   IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Ohio

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John McFarland

14. MOTHER'S MAIDEN NAME: Alice J. Goodriah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
    (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 216-12-4872B

17. INFORMANT: Mrs. Alice Greenwell — Address: Bristol, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of pancreas — INTERVAL BETWEEN ONSET AND DEATH: one year

157X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONOITIONS CONTRIBUTING TO OEATH BUT NOT RELATEO TO THE TERMINAL DISEASE CONOITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ ND ☒

20a. ACCIOENT WAS UNOERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Aug. 1, 1967, to Dec 2, 1967, that (I) (we) last saw the deceased alive on Dec. 1 1967, and that death occurred at 6 4 M, from the causes and on the date stated above.

22a. SIGNATURE: Willard F. Smith — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 12/2/67

22c. PHYSICIAN'S NAME (Type): Willard F. Smith, MD

22d. ADDRESS: Shady Side, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Dec. 4, 1967

23c. NAME OF CEMETERY OR CREMATORY: Friendship Chr. Cemetery

23d. LOCATION (City, town or county) (State): Friendship A. A. Co. Md.

24. FUNERAL DIRECTOR: Hutchins Funeral Home — ADDRESS: Owings, Maryland

25a. REC'D BY REGISTRAR — DATE: DEC 5 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Jones

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16300

CERTIFICATE OF DEATH

16291

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 132 Archwood Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Walter — Middle: Herman — Last: ASCHE

4. DATE OF DEATH: Month: December — Day: 17 — Year: 19 67

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 30, 1899
9. AGE (In years last birthday): 68 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): METALURGIST
10b. KIND OF BUSINESS OR INDUSTRY: 45 ENGINEER COMM'T
11. BIRTHPLACE (County & State, or foreign country): Germany
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: UNKN.
14. MOTHER'S MAIDEN NAME: UNKN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: ELIZABETH M. ASCHE #2 — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Obstructive Jaundice — INTERVAL BETWEEN ONSET AND DEATH: 1 Month
151 X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Metastatic — 3 mos
DUE TO (c): Gastric Adenocarcinoma — 15 mos

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Day, Yeor Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from July, 1966, to Dec., 1967, that (I) (~~not~~) last saw the deceased alive on Dec. 16 1967, and that death occurred at 11:45 A.M. from causes and on the date stated above.

22a. SIGNATURE: Peter F. Verkouw M.D. — ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12-18-67
22c. PHYSICIAN'S NAME (Type): PETER F. VERKOUW M.D.
22d. ADDRESS: 1407 Forest Drive, Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 12/19/1967
23c. NAME OF CEMETERY OR CREMATORY: HILLCREST CEM.
23d. LOCATION (City or Town) (County) (State): ANNAPOLIS MD

24. FUNERAL DIRECTOR: JOHN M. TAYLOR SON — ADDRESS: ANNAPOLIS MD.
25a. REC'D BY REGISTRAR DATE: DEC 21 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16301

CERTIFICATE OF DEATH

16293

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 20 M 1/66

1. PLACE OF DEATH a. COUNTY: Anne Arundel Co. — MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: Md. — b. COUNTY: ~~XXXXXXXXXXX~~ Anne Arundel Co.
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie — c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 021
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): North Arundel Hospital 54	d. STREET ADDRESS: 400 Cresswell Ave. 21225 — e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Arthur E. — Middle: (ARTHUR EUGENE) — Last: Atkinson	4. DATE OF DEATH: Month 12-12 — Doy — Year 19 67						
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH: 9-10-06	9. AGE (In years last birthday): 61 yrs.	IF UNDER 1 YEAR: Months / Doys	IF UNDER 24 HRS.: Hours / Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Cost Acct	10b. KIND OF BUSINESS OR INDUSTRY: Westinghouse	11. BIRTHPLACE (County & State, or foreign country): Baltimore, Md.	12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME: Arthur E. Atkinson	14. MOTHER'S MAIDEN NAME: Mary Van Sant						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT — Address 21225: Mrs. Viola P. Atkinson 400 Cresswell Ave.					

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Massive hypocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 6 da
DUE TO (b): Arteriosclerotic Heart Disease — 4 yrs
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last. — DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hiatal Hernia — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)			
20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	

21. I certify that (I) (this hospital) attended the deceased from 12-6, 19 67 to 12-12 19 67, that (I) (we) last saw the deceased alive on 12-11 19 67, and that death occurred at 4:45 M, from causes and on the date stated above.

22a. SIGNATURE: [signature] — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 12-12-67

22c. PHYSICIAN'S NAME (Type) — 22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE THEREOF: 12/14/67	23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill	23d. LOCATION (City or Town) (County) (State): Anne Arundel Co.	
24. FUNERAL DIRECTOR — ADDRESS: McCully Funeral Home 237 Patapsco Ave. 21225	25a. REC'D BY REGISTRAR — DATE: DEC 18 1967	25b. REGISTRAR'S SIGNATURE: [signature] Deputy Judge		

Mrs. Viola T. Adkinson
237 Petaluca Ave. 21235

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16302

16294

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 2 hrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town): Churchton
d. STREET ADDRESS: Box-36
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William — Middle: H. — Last: AYERS

4. DATE OF DEATH: Month: December — Day: 29 — Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ — NEVER MARRIED ☐ — WIDOWED ☐ — DIVORCED ☐

8. DATE OF BIRTH: 2-10-40

9. AGE (In years last birthday): 27 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FINANCE

10b. KIND OF BUSINESS OR INDUSTRY: LOAN Co.

11. BIRTHPLACE (County & State, or foreign country): OHIO

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: H. W. AYERS

14. MOTHER'S MAIDEN NAME: DOROTHY THORTON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES (If yes give war or dates of service): KOREA?

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: GERALDINE AYERS #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Lobar Pneumonia - left — INTERVAL BETWEEN ONSET AND DEATH: 48 hrs.
DUE TO (b): due to influenza — 4 days
DUE TO (c):
480 X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): ADRENAL CORTICAL ATROPHY

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased ~~from~~ on Dec 29, 1967, to ____, 19__, that (I) (~~we~~) last saw the deceased alive on Dec 29 1967, and that death occurred at 12:20 pM, from causes and on the date stated above.

22a. SIGNATURE: Willard F. Smith — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 12/29/67

22c. PHYSICIAN'S NAME (Type): Willard F. Smith, M.D.

22d. ADDRESS: Shady Side, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 1-2-1968

23c. NAME OF CEMETERY OR CREMATORY: ROSEDALE MEM. PARK

23d. LOCATION (City or Town) (County) (State): BUCKS Pa.

24. FUNERAL DIRECTOR — ADDRESS: John M. Taylor Sons Annapolis, Md.

25a. REC'D BY REGISTRAR — DATE: JAN 3 1968

25b. REGISTRAR'S SIGNATURE: Charles Jaeger

16303

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 4 Film G396 1/12/68 kk

CERTIFICATE OF DEATH

16295

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (page 2 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 214 Ditty Court

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland — b. COUNTY Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie — 02-1
d. STREET ADDRESS 214 Ditty Court
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Annette — Middle M. — Last Barnwell
4. DATE OF DEATH: Month December — Day 29 — Year 19 67

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Sept. 8, 1911
9. AGE (In years last birthday): 56 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Luther Rohrbaugh
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): None
16. SOCIAL SECURITY NO.: 213-20-7196
17. INFORMANT: Mr. Henry J. Barnwell (husband) # 2 — Address: Same as

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b): ASHD
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): HCVD

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 7/15/57, to 12/29/67, that (I) (we) last saw the deceased alive on 2/23/67, and that death occurred at 4 AM, from causes and on the date stated above.

22a. SIGNATURE: Joseph Taler, M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/29/67
22c. PHYSICIAN'S NAME (Type): JOSEPH TALER
22d. ADDRESS: 95 Aylesbury Rd. Glen Burnie, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Jan. 2, 1968
23c. NAME OF CEMETERY OR CREMATORY: Glen Haven Memorial Pk.
23d. LOCATION (City or Town) (County) (State): Glen Burnie, Maryland

24. FUNERAL DIRECTOR: Singleton Funeral Home — ADDRESS: E B Fleming Glen Burnie, Md.
25a. REC'D BY REGISTRAR DATE: JAN 2 1968
25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16304

CERTIFICATE OF DEATH

16296

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH a. COUNTY: Anne Arundel — MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: Maryland b. COUNTY: Anne Arundel
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie — c. LENGTH OF STAY IN 1b: O.O.A	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): North Arundel	d. STREET ADDRESS: 1303 Heathwood Road — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
FRANCIS	L.	BELL	Dec.	10	19 67

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ / NEVER MARRIED ☐ / WIDOWED ☐ / DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White		21 May 1921	46 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
	Fisher Body	Newburg, West Va.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Carl Bell	Iva Knott

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
Yes WW II	232426021	Mary Ann Bell (Wife) Same as # 2

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Coronary thrombosis	2 hr
DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		
DUE TO		
(c)		

4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Dec 10, 19 67, to Dec 10, 19 67, that (I) (we) last saw the deceased alive on Dec 10 19 67, and that death occurred at 1 00 P M, from causes and on the date stated above.

22a. SIGNATURE	M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐	22b. DATE SIGNED
Robert Dabolins		12-11-67

22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS
Robert Dabolins, M.D.	400 Crain Hwy. N.W. Glen Burnie, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	12/13/67	Balto. Nat'l. Cemetery	Baltimore, Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Singleton Funeral Home/ Glen Burnie, Md.	DEC 12 1967	J. Charles Judge

7 1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16305

CERTIFICATE OF DEATH

16297

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. **PLACE OF DEATH**
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL-GLEN BURNIE
c. LENGTH OF STAY IN 1b: 1 DAY
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): NORTH ARUNDEL GENERAL HOSPITAL

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ANNE ARUNDEL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL-GLEN BURNIE
d. STREET ADDRESS: 202 WICKLOW AVE FERNDALE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: BURTON — Middle: H. — Last: BERRY

4. **DATE OF DEATH**: Month: DECEMBER — Day: 18 — Year: 19 67

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April ~~August~~ 11, 1892

9. AGE (In years last birthday): 75 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Retired

11. BIRTHPLACE (County & State, or foreign country): NORTH CAROLINA

12. CITIZEN OF WHAT COUNTRY? U SA

13. FATHER'S NAME: James E. Berry, Sr.

14. MOTHER'S MAIDEN NAME: Evelyn W. Williamson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 243-20-0738

17. **INFORMANT** Address: Mrs. Alma Berry, same as 2

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebr-vascular accident — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b): Arteriosclerotic heart disease — 10 yrs
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4200

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour o.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Dec 17, 1967, to Dec 18, 1967, that (I) (we) last saw the deceased alive on Dec 18 1967, and that death occurred at 10:30 A.M, from causes and on the date stated above.

22a. SIGNATURE: Joseph Taler, M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 12/18/67

22c. PHYSICIAN'S NAME (Type): JOSEPH TALER, M.D.

22d. ADDRESS: 95 AQUAHART Rd. Glen Burnie, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 20 Dec. 1967

23c. NAME OF CEMETERY OR CREMATORY: Soule Cemetery

23d. LOCATION (City or Town) (County) (State): Swans Quarter, N. C. Ma.

24. FUNERAL DIRECTOR — ADDRESS: Kirkley Funeral Home, Glen Burnie, Md.

25a. REC'D BY REGISTRAR DATE: DEC 20 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16306

CERTIFICATE OF DEATH

16298

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pasadena
c. LENGTH OF STAY IN 1b: 25 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): Rt. 2 Pardise Beach

2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before odmission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporote limits, write RURAL ond give neorest town): Pasadena
d. STREET ADDRESS: Rt. 2 Pardise Beach
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First FREDERICK — Middle K. — Lost BIENER
4. DATE OF DEATH: Month December — Doy 4 — Year 19 67

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 7 May 1901
9. AGE (In yeors lost birthdoy): 66 yrs.
IF UNDER 1 YEAR: Months ___ Doys ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): (retd)
10b. KIND OF BUSINESS OR INDUSTRY: Bieners Bakery
11. BIRTHPLACE (County & Stote, or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Frederick K. Biener
14. MOTHER'S MAIDEN NAME: (unknown)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes give wor or dotes of service)
16. SOCIAL SECURITY NO.: 214-34-3146
17. INFORMANT: Mrs. Barbar[a] Biener — Address: Same as # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): Obstruction Adenocarcinoma Sigmoid — INTERVAL BETWEEN ONSET AND DEATH: 2 Mos.
DUE TO (b): Metastasis Liver & Peritoneal Cavity
DUE TO (c): Edema & Emaciation
Conditions, if ony, which gove rise to immediote couse (o), stoting the underlying couse lost.
1533

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20o. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19
20d. INJURY OCCURRED While ot work ☐ Not While ot work ☐
20e. PLACE OF INJURY (Home, form, foctory, street, office bldg., etc.)
20f. (City or town) (County) (Stote)

21. I certify that (I) (this hospital) attended the deceased from July 26, 1967, to Date, 19___, that (I) (we) last saw the deceased alive on July 26 19 67, and that death occurred at 10 A.M., from causes and on the date stated above.

22o. SIGNATURE: William G. Geyer — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Dec 5-67
22c. PHYSICIAN'S NAME (Type): William G. Geyer
22d. ADDRESS: 156 Milton Ave. - Baltimore, Md.

23o. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12/6/67
23c. NAME OF CEMETERY OR CREMATORY: Glen Haven Memorial Pk.
23d. LOCATION (City or Town) (County) (Stote): Glen Burnie, Maryland

24. FUNERAL DIRECTOR ADDRESS: Singleton Funeral Home/Glen Burnie, Md.
25o. REC'D BY REGISTRAR DATE: DEC 6 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires thot the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers — Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

item 18 film 396 1-23-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16307

CERTIFICATE OF DEATH

16299

CLEARED THROUGH ANNE ARUNDEL COUNTY MEDICAL EXAMINER DR. ELMER LINDHART.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH a. COUNTY: Anne Arundel — MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: Maryland — b. COUNTY: Prince George
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b: 5 mos
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bowie	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Naval Hospital, Annapolis, Md.	d. STREET ADDRESS: 12400 Melody Turn, Bowie, Md. — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒
3. NAME OF DECEASED (Type or print): First Cecile — Middle Ann Marie — Last Boissonneault	4. DATE OF DEATH: Month December — Day 12 — Year 67
5. SEX: Female — 6. COLOR OR RACE: Cauc. — 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH: 4 Sept. 1925 — 9. AGE (In years last birthday): 42 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife — 10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country): Bedford, Maine — 12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Edgar E. Martel	14. MOTHER'S MAIDEN NAME: Amanda Tanguay
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service)	16. SOCIAL SECURITY NO.: 005 22 1877 — 17. INFORMANT: Husband — Address: Raymond Boissonneault

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): PENDING Undetermined — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

7955

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Deceased was an Epileptic on Dilantin Therapy. It is possible death was due to a seizure & resulting cardiac arrhythmia. — 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 — 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from DOA 12-12, 1967, to _____, 19___, that (I) (we) last saw the deceased alive an _____ 19___, and that death occurred at 1955 M, from causes and an the date stated above.

22a. SIGNATURE — M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): A. C.J. BRICKEL, LT MC USNR — 22d. ADDRESS: NAVAL HOSPITAL, ANNAPOLIS, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	12-18-1967	St Joseph Church Cem.	Biddeford, Maine

24. FUNERAL DIRECTOR: NALLEY'S FUNERAL HOME — ADDRESS: 3200 Rhode Island Ave. N.E., WASHINGTON, D.C. — 25a. REC'D BY REGISTRAR DATE: DEC 18 1967 — 25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16308

CERTIFICATE OF DEATH

16300

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: Anne Arundel County
Crownsville State Hospital MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: since Jan 29/67
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Calvert
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Prince Frederick
d. STREET ADDRESS: —
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: Edgar — Middle: L — Last: Bowen

4. DATE OF DEATH: Month: 12 — Day: 29 — Year: 1967

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 11/26/86

9. AGE (In years last birthday): 81 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, ~~even if retired~~): Seam stress

10b. KIND OF BUSINESS OR INDUSTRY: Retired

11. BIRTHPLACE (County & State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Silas W Bowen

14. MOTHER'S MAIDEN NAME: Fanny Monnett

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): —

16. SOCIAL SECURITY NO.: 218-54-7960

17. INFORMANT: Short — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac Decompensation — INTERVAL BETWEEN ONSET AND DEATH: 2-3 yrs.
DUE TO (b): Uremia — Several days
DUE TO (c): —
4374 Conditions, if ony, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Anemia, Malnutrition, Chronic Brain Syndrome

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 11/29, 19 67, to 12/29, 19 67, that (I) (we) last saw the deceased alive on 12/29/67 19 ___, and that death occurred at 9P M, from causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☒ STAFF PHYS. ☐

22b. DATE SIGNED: 1/3/68

22c. PHYSICIAN'S NAME (Type): (BENEDICT M.D.)

22d. ADDRESS: Crownsville State Hospital

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: January 4, 1968

23c. NAME OF CEMETERY OR CREMATORY: Central Cemetery

23d. LOCATION (City or Town) (County) (State): Barstow, Calvert, Md.

24. FUNERAL DIRECTOR: A.A. Harkness & Son, ADDRESS: Port Republic, Md.

25a. REC'D BY REGISTRAR DATE: JAN 3 1968

25b. REGISTRAR'S SIGNATURE: [signature] Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

16309

CERTIFICATE OF DEATH

16301

1. PLACE OF DEATH
   a. COUNTY: Anne Arundel — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Brooklyn Park
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 120 Audrey Ave. 21225

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Anne Arundel
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Brooklyn Park
   d. STREET ADDRESS: 120 Audrey Ave. 21225
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Roy	Miller	Bowers	Dec.	19	1967

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White		March 18, 1900	67 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Clergyman	Nazarene Church	Ambler, Pennsylvania	U. S. A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Harry Bowers	Mary Hoffman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown)	(If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
Yes	World War 1		Mrs. Christine W. Bowers	120 Audrey Ave. 21225

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Acute Myocardial Infarction	1 Hour
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b)	Arteriosclerotic Cardio Vascular Dis	4 years
DUE TO (c)		

4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 23 months, 19 67, to 19 DEC, 19 67, that (I) (we) last saw the deceased alive on 15 Dec 19 67, and that death occurred at 5:30 M, from the causes and on the date stated above.

22a. SIGNATURE	M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22b. DATE SIGNED
Benjamin Berdann		12-21-67

22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS
Benjamin Berdann, M.D.	615 Hammonds Lane

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
Burial	12/22/67	Baltimore, National	Baltimore, Maryland

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
McCully Funeral Home	237 Patapsco Ave. 21225	DEC 26 1967	J. Charles Judge

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

16310

CERTIFICATE OF DEATH

16302

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. **PLACE OF DEATH**
   a. COUNTY: Anne Arundel — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mayo
   c. LENGTH OF STAY IN 1b: 19 Months
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Anne Arundel
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mayo
   d. STREET ADDRESS:
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Elta — Middle: Armeda — Last: BOWMAN

4. **DATE OF DEATH**: Month: Dec. — Day: 9 — Year: 1967

5. SEX: F. — 6. COLOR OR RACE: W. — 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: March 8. 1885 — 9. AGE (In years last birthday): 82 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife — 10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME — 11. BIRTHPLACE (County & State, or foreign country): Kirby, W. Va. — 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JAMES LOY — 14. MOTHER'S MAIDEN NAME: RACHAEL PETERS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give were or dates of service): No — 16. SOCIAL SECURITY NO.: 212-24-3945 — 17. INFORMANT: Mrs. Mildred Rickman — Address: Mayo, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral thrombosis and Cardiac failure — INTERVAL BETWEEN ONSET AND DEATH: 8½ days

DUE TO (b): Arteriosclerotic Cardiovascular disease — 10 years

Conditions, if any, which geva rise to immedieta ceuse (a), steting the underlying ceuse last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour e.m. p.m. — Month, Day, Yeer: 19 — 20d. INJURY OCCURRED: While at work ☐ Not While at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Nov. 30, 1967 to Dec. 9, 1967, that (I) (we) last saw the deceased alive on Dec. 9, 1967, and that death occurred at 7:30 M, from the causes and on the date stated above.

22a. SIGNATURE: Sylvia M. Lyn M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: Dec. 9, '67

22c. PHYSICIAN'S NAME (Type): Sylvia M. Lyn — 22d. ADDRESS: Rt 1 Box 244 Edgewater, Md. 21037

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL — 23b. DATE THEREOF: 12/12/67 — 23c. NAME OF CEMETERY OR CREMATORY: HOTTS CHAPEL — 23d. LOCATION (City, town or county) (State): KIRBY W. VA

24. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: Powell & Hartzler Woodsboro Md — 25a. REC'D BY REGISTRAR DATE: DEC 12 1967 — 25b. REGISTRAR'S SIGNATURE: Richard Jaeger

VR A15 (4)
20M 5-63

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16371

CERTIFICATE OF DEATH

16303

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Freetown
c. LENGTH OF STAY IN 1b: 18 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Box 325 Glen Burnie P.O. Md

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: A.A. Co
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Freetown 02-1
d. STREET ADDRESS: Box 325 Glen Burnie P.O.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lenora — Middle: NMN — Last: Brown

4. DATE OF DEATH: Month: 12 — Day: 24 — Year: 19 67

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 6-9-1889

9. AGE (In years last birthday): 78 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY: *****

11. BIRTHPLACE (County & State, or foreign country): Anne Arundel Co

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Alfred Jerome Manns

14. MOTHER'S MAIDEN NAME: Emma Curry

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No — ****

16. SOCIAL SECURITY NO.: 217-07-0001

17. INFORMANT: Evelyn Glenn — Address: Glen Burnie P.O.Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hyp. C.V.D. & Uremia — Cerebral Thrombosis
DUE TO
(b): Gen Art
DUE TO
(c):
443X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1960, 19__ to 1967, 19__, that (I) (we) last saw the deceased alive on 12-15-67 19__, and that death occurred at 7:30 PM, from causes and on the date stated above.

22a. SIGNATURE: Robert R. Hahn — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 12-25-67

22c. PHYSICIAN'S NAME (Type): Robert R. HAHN

22d. ADDRESS: P.O. Box 73 Severna Park, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 12-27-67

23c. NAME OF CEMETERY OR CREMATORY: Town Neck

23d. LOCATION (City or Town) (County) (State): Anne Arundel Md

24. FUNERAL DIRECTOR: C.E. Hicks, III — ADDRESS: Annapolis, Md

25a. REC'D BY REGISTRAR DATE: JAN 2 1968

25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16312

CERTIFICATE OF DEATH

16304

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. **PLACE OF DEATH**
   a. COUNTY: An Arundel — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
   c. LENGTH OF STAY IN 1b: 4 days
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): North Arundel Conval. Center

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Md.
   b. COUNTY: Anne Arundel
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Severn
   d. STREET ADDRESS: Box ~~67~~ #36
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Rosemary — Middle: Buckingham — Last:

4. **DATE OF DEATH**: Month: 12 — Day: 23 — Year: 1967

5. SEX: Fe

6. COLOR OR RACE: Cauc.

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 11/25/39

9. AGE (In years last birthday): 28 yrs.

IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sales Lady

10b. KIND OF BUSINESS OR INDUSTRY: Dept. Store

11. BIRTHPLACE (County & State, or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Walter L. Boushell

14. MOTHER'S MAIDEN NAME: Mildred Morrissette

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): None

16. SOCIAL SECURITY NO.:

17. **INFORMANT** Address: Mrs Mildred Law (Mother) — Same as #2

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Melanoma — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
(b): Generalized melanomatosis — 2 years
DUE TO
(c): Heart failure

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

1909

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Nov. 29, 1963, to Dec. 23, 1967, that (I) (we) last saw the deceased alive on Dec. 23 1967, and that death occurred at 4:20 M, from causes and on the date stated above.

22a. SIGNATURE: Robert DaBolin — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 12/23/67

22c. PHYSICIAN'S NAME (Type): Robert DaBolin, M.D.

22d. ADDRESS: 400 Crain Hwy. N. Gt.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Dec. 26, 67

23c. NAME OF CEMETERY OR CREMATORY: Loudon Park Cemetery

23d. LOCATION (City or Town) (County) (State): Baltimore Md.

24. FUNERAL DIRECTOR: F. V. Singleton — ADDRESS: Glen Burnie, Md.

25a. REC'D BY REGISTRAR DATE: DEC 27 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

16313 16305

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Millersville
c. LENGTH OF STAY IN 1b: 3 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Knollwood Manor Nursing Home

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md. b. COUNTY: AA
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pasadena 02.1
d. STREET ADDRESS: 415 Sylview Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Joseph Middle: Henry Last: Budaj
4. DATE OF DEATH: Month: December Day: 25, Year: 19 67

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 15 March 1894
9. AGE (In years last birthday): 73 yrs.
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Rigger
10b. KIND OF BUSINESS OR INDUSTRY: Bethlehem Steel
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes (If yes give war or dates of service): WW 1
16. SOCIAL SECURITY NO.:
17. INFORMANT Address: Mrs. Florence Majerowicz, same as 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 6 hours
481 X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Viral respiratory infection (Influenza?) 1 day
DUE TO (c): -
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Urinary tract infection, Arteriosclerosis, Chronic organic brain syndrome
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from July, 1965 to 25 Dec, 1967, that (I) (we) last saw the deceased alive on 26 Nov 1967, and that death occurred at 4:15 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Charles W. Kinzer M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 27 Dec 1967
22c. PHYSICIAN'S NAME (Type): Charles W. Kinzer, M. D.
22d. ADDRESS: 16 Murray Ave., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 28 Dec. 1967
23c. NAME OF CEMETERY OR CREMATORY: Holy Rosary Cemetery
23d. LOCATION (City, town or county) (State): Baltimore, Maryland

24. FUNERAL DIRECTOR ADDRESS: Kirkley Funeral Home, Glen Burnie, Md.
25a. REC'D BY REGISTRAR DATE: DEC 28 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16314

CERTIFICATE OF DEATH

16306

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 18 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before odmission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporote limits, write RURAL ond give nearest town): City - Annapolis
d. STREET ADDRESS: 119 Clay Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Sophie — Middle: Brown — Lost: BUNCH
or- Sophia -Elizabeth-or

4. DATE OF DEATH: Month: December — Doy: 24, — Year: 19 67

5. SEX: Female
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: January 11, 1906
9. AGE (In yeors last birthday): 61 yrs.
IF UNDER 1 YEAR: Months / Doys — IF UNDER 24 HRS.: Hours / Min.

10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Chamber maid
10b. KIND OF BUSINESS OR INDUSTRY: Hotel
11. BIRTHPLACE (County & Stote, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Mary Gross

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes give wor or dotes of service): ****
16. SOCIAL SECURITY NO.: 220-03-5399
17. INFORMANT: Helen Dancey — Address: 119 Clay St Annapolis Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), ond (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): Pulmonary Embolus
DUE TO (b): Cerebral Hemorrhage
DUE TO (c): Probable Carcinoma of the Stomach
Conditions, if ony, which gove rise to immediote couse (o), stoting the underlying couse last.
150X
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20o. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19
20d. INJURY OCCURRED While ot work ☐ Not While ot work ☐
20e. PLACE OF INJURY (Home, farm, foctory, street, office bldg., etc.)
20f. (City or town) (County) (Stote)

21. I certify that (I) (this hospital) attended the deceased from Sept 14, 1967, to Dec 24, 1967 that (I) (we) last saw the deceased alive an December 24 1967, and that death occurred at 9:12 p.m., from causes and on the date stated above.

22o. SIGNATURE: R. L. Richardson M.D.
M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/27/67
22c. PHYSICIAN'S NAME (Type): R. L. Richardson, M.D.
22d. ADDRESS: 110 Clay St Annapolis Md

23o. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12-28-67
23c. NAME OF CEMETERY OR CREMATORY: Brewer Hill
23d. LOCATION (City or Town) (County) (Stote): Annapolis A.A. Md

24. FUNERAL DIRECTOR: C.E. Hicks,111
ADDRESS: Annapolis, Md
25o. REC'D BY REGISTRAR DATE: JAN 2 1968
25b. REGISTRAR'S SIGNATURE: J Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form DHS Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16315

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16307

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town):
d. STREET ADDRESS: Rt 1 Box 5 Crownsville
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
PEARL	ANN	CARICO	December	26,	19 67

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White		Feb-2-1911	56 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
DOMESTIC		Pound - VA	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
LABORN	ADA MEADE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
— —		ORLENA E. CARICO	3038-E-North

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary embolism — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
(b):
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
465X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES XXX NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy XX, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes XX, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Edward F. Wilson M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐
EXAMINER'S NAME (Type): Edward F. Wilson, M.D.
Address (Street, city, town, or county):
22. DATE SIGNED: December 29, 1967

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	1/2/68	Mt. Carmel Cem.	5712 Ordell Ln (Md

24. FUNERAL DIRECTOR: T. Tucker (1920 Eastern Ave) — ADDRESS

25a. REC'D BY REGISTRAR DATE: JAN 2 1968 — 25b. REGISTRAR'S SIGNATURE: Jesse J. Judge

VR A15ME (5) 6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16316

CERTIFICATE OF DEATH

16308

1. PLACE OF DEATH
a. COUNTY: A.A. Co. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
c. LENGTH OF STAY IN 1b: 1 Day
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): A.A. Gen Hosp.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MD. b. COUNTY: A.A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Severna Park
d. STREET ADDRESS: Riggs Ave. (208)
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Edith — Middle: Skipwith — Last: Carr.
4. DATE OF DEATH: Month: 12 — Day: 9 — Year: 67 · 19

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 6-19-97
9. AGE (In years last birthday): 70 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (County & State, or foreign country): Missouri
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Peyton H. Skipwith
14. MOTHER'S MAIDEN NAME: Ellen Powell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 214-03-5271
17. INFORMANT: A - H.S. Carr — Address: Severna Pk, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Respiratory Failure
DUE TO (b): Aspiration of Vomitus
DUE TO (c): Severe Emphysema - Gastritis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Yeor Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factary, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1959, 19 40, to 1967, 19___, that (I) (we) last saw the deceased alive on 12-9-67 19___, and that death occurred at 8 A.M. from causes and on the date stated above.

22a. SIGNATURE: Robert R. Hahn — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12-9-67
22c. PHYSICIAN'S NAME (Type): Robert R. HAHN
22d. ADDRESS: P.O. Box 73 Severna Park

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12/12/67
23c. NAME OF CEMETERY OR CREMATORY: St James Ch. Cem
23d. LOCATION (City or Town) (County) (State): Lothian A.A. Md
24. FUNERAL DIRECTOR: Robert L. Barranco — ADDRESS: Severna Pk. Md
25a. REC'D BY REGISTRAR DATE: DEC 13 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16317

CERTIFICATE OF DEATH

16309

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
c. LENGTH OF STAY IN 1b: L.IE
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ANNE ARUNDEL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS (EASTPORT)
d. STREET ADDRESS: 39 Dean St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: SAMUEL — Middle: — Last: CARR

4. DATE OF DEATH: Month: 12 — Day: 10 — Year: 1967

5. SEX: M.

6. COLOR OR RACE: NEGRO

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 7-16-16

9. AGE (In years last birthday): 51 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country): ANNE ARUNDEL, MD

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: William CARR

14. MOTHER'S MAIDEN NAME: Alice

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service)

16. SOCIAL SECURITY NO.: UNKNOWN

17. INFORMANT — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Respiratory failure	2 hrs
DUE TO (b)	Cardiac Decompensation	2 days
DUE TO (c)	Bilateral Pneumonitis	2 days

434.4
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that ~~I~~ (this hospital) attended the deceased from 12/7, 1967, to 12/10, 1967, that (I) (~~we~~) last saw the deceased alive on 12/10 1967, and that death occurred at 4A M, from causes and on the date stated above.

22a. SIGNATURE: Charles A. Greene M.D.
M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 12/10/67

22c. PHYSICIAN'S NAME (Type): Charles A. Greene, M.D.

22d. ADDRESS: Johns Hopkins Hospital-Baltimore

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF: 12/14/67

23c. NAME OF CEMETERY OR CREMATORY: Broadneck Cemetery

23d. LOCATION (City or Town): Broadneck B.A. (County): (State): Md.

24. FUNERAL DIRECTOR — ADDRESS: J.B. Johnson 844 West Stan

25a. REC'D BY REGISTRAR DATE: DEC 11 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Jones

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 25M 1/67

16318

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

16310

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 27 Murray Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: James — Middle: Preston — Last: CHANCE

4. DATE OF DEATH: Month: December — Day: 8 — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: September 6, 1904

9. AGE (In years last birthday): 63 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): B & O R.R. Co.

10b. KIND OF BUSINESS OR INDUSTRY: RAILROAD

11. BIRTHPLACE (County & State, or foreign country): Annapolis, Maryland

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: BENJAMIN F. CHANCE

14. MOTHER'S MAIDEN NAME: KATHERINE McNEMAR

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes give war or dates of service): —

16. SOCIAL SECURITY NO.:

17. INFORMANT: Address: MRS. JOHN GREER #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): L. Cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
(b): Arteriosclerotic Cerebral vascular disease — Unknown
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
332 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Bronchopneumonia

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4/67, 19__, to 12/8, 19 67, that (I) (~~we~~) last saw the deceased alive on 12/7 19 67, and that death occurred at 12:55 A.M. M. from causes and on the date stated above.

22a. SIGNATURE: L. Biern
M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 12/8/67

22c. PHYSICIAN'S NAME (Type): Robert Biern, M. D.

22d. ADDRESS: 121 Cathedral St., Annapolis, Maryland.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 12-10-67

23c. NAME OF CEMETERY OR CREMATORY: St. Hunes

23d. LOCATION (City or Town) (County) (State): Annapolis A.H. Md.

24. FUNERAL DIRECTOR: John M. Taylor & Sons

ADDRESS: Annapolis, Md.

25a. REC'D BY REGISTRAR DATE: DEC 12 1967

25b. REGISTRAR'S SIGNATURE: [illegible]

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

16319

CERTIFICATE OF DEATH

16311

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. **PLACE OF DEATH**
   a. COUNTY: Anne Arundel — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Anne Arundel
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
   d. STREET ADDRESS: 1109 Eastport Terrace
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Earl — Middle: Fred — Last: CHANEY Sr.

4. **DATE OF DEATH**: Month: December — Day: 31 — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 23, 1910

9. AGE (In years last birthday): 57 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): GUARD

10b. KIND OF BUSINESS OR INDUSTRY: YACHT YARD

11. BIRTHPLACE (County & State, or foreign country): ANNAPOLIS Maryland

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: THOMAS CHANEY

14. MOTHER'S MAIDEN NAME: EMMA BROWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): YES (If yes give war or dates of service): WW II

16. SOCIAL SECURITY NO.: 220 05 1471

17. INFORMANT: MADELEINE E. CHANEY — Address: #2

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac Arrest — INTERVAL BETWEEN ONSET AND DEATH: immediate
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Carcinoma of Stomach — INTERVAL BETWEEN ONSET AND DEATH: unknown
DUE TO
(c):

151X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) ~~(this hospital)~~ attended the deceased from November, 1967 to 12/31, 1967, that (I) ~~(we)~~ last saw the deceased alive on 12/31 1967, and that death occurred at 2:10 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Richard I Hachman M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 1/2/68

22c. PHYSICIAN'S NAME (Type): Richard I Hachman, MD

22d. ADDRESS: 16 Murray Ave, Annapolis, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 1-4-68

23c. NAME OF CEMETERY OR CREMATORY: St. ANNE'S

23d. LOCATION (City, town or county) (State): ANNAPOLIS A.A. MD.

24 FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: John M. Taylor & Sons Annapolis, Md.

25a. REC'D BY REGISTRAR DATE: JAN 4 1968

25b. REGISTRAR'S SIGNATURE

VR A1S (4)
20M 5-68

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health priar to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16320

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16312

1. **PLACE OF DEATH**
   a. COUNTY: Anne Arundel — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 196 Clay Street

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: A. A.
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis 021
   d. STREET ADDRESS: 196 Clay Street
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First DOROTHY Middle Blackstone Last COATES

4. **DATE OF DEATH**: Month December Day 2 Year 19 67

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 12-24-1936

9. AGE (In years last birthday): 30 yrs.
   IF UNDER 1 YEAR: Months ___ Days ___
   IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Herbert Blackstone

14. MOTHER'S MAIDEN NAME: Dorsey Gross

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Dorsey Moulden — Address: 196 Clay St.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Lobar Pneumonia
490X
DUE TO
(b):
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held on Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Edward F. Wilson M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐

EXAMINER'S NAME (Type): Edward F. Wilson, M.D.

Address (Street, city, town, or county):

22. DATE SIGNED: December 2, 1967

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 12-6-1967

23c. NAME OF CEMETERY OR CREMATORY: John Wesley

23d. LOCATION (City or Town) (County) (State): Annapolis Md.

24. FUNERAL DIRECTOR: William Reese — ADDRESS: Anna. Md.

25a. REC'D BY REGISTRAR DATE: DEC 4 1967

25b. REGISTRAR'S SIGNATURE:

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16321

CERTIFICATE OF DEATH

16313

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): North Arundel Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md. b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
d. STREET ADDRESS: 1210 Broadview Blvd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Edgar Middle: P. Last: Cockerill
4. DATE OF DEATH: Month: 12-19 Day: Year: 19 67
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED XX ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 6-16-03
9. AGE (In years last birthday): 64 yrs.
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter
10b. KIND OF BUSINESS OR INDUSTRY: Self- Employed
11. BIRTHPLACE (County & State, or foreign country): West Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Cockerill
14. MOTHER'S MAIDEN NAME: Alice Pritchard

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give wor or dates of service):
16. SOCIAL SECURITY NO.: 215-05-4967
17. INFORMANT: Patients Chart. Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Massive pulmonary embolism
DUE TO (b): Carcinoma of ascending colon
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): arteriosclerosis - generalized
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from Dec. 8, 1967, to Dec. 19, 1967 that (I) (~~we~~) last saw the deceased alive an Dec. 19 1967, and that death occurred 5:20 AM, from causes and an the date stated above.

22a. SIGNATURE: E. Roderick Shipley M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: December 21, 1967
22c. PHYSICIAN'S NAME (Type): E. Roderick Shipley, M.D.
22d. ADDRESS: Camp Meade Rd., Linthicum, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 22 Dec. 67
23c. NAME OF CEMETERY OR CREMATORY: Meadowridge Memorial
23d. LOCATION (City or Town) (County) (State): Elkridge, Maryland

24. FUNERAL DIRECTOR ADDRESS: Kirkley's Funeral Home, Glen Burnie, Md.
25a. REC'D BY REGISTRAR DATE: DEC 22 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

16322

CERTIFICATE OF DEATH

16314

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. **PLACE OF DEATH** — a. COUNTY: Anne Arundel Co. MARYLAND; b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Glen Burnie Md.; c. LENGTH OF STAY IN 1b:

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission) — a. STATE: Maryland; b. COUNTY: Baltimore; c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore, Maryland 3044; d. STREET ADDRESS: 1014 W. Lombard Street; e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Home Maternity Home

3. **NAME OF DECEASED** (Type or print): First: John; Middle: J.; Last: Coleman

4. **DATE OF DEATH**: Month: 12; Day: 22; Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 2/28/96

9. AGE (In years last birthday): 71 yrs.

IF UNDER 1 YEAR: Months: ; Days: ; IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Street Cleaner

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: John J. Coleman

14. MOTHER'S MAIDEN NAME: Kate Bailey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): Yes 5/12/13 to 5/2/18

16. SOCIAL SECURITY NO.: 218-04-2070-A

17. INFORMANT — Address: Mrs Brughoff - Friend (deceased)

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Pulmonary Congestion — INTERVAL BETWEEN ONSET AND DEATH: 2 days.

DUE TO (b): Arteriosclerotic Cardiovascular Disease — Unknown.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Senility — Unknown.

4221

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 12-1, 1964 to 12-22, 1967, that (I) (we) last saw the deceased alive on 12-22 1967, and that death occurred at 2 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Richard H. Hunt M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Richard H. Hunt

22d. ADDRESS: 100 Cherry Lane, Glen Burnie, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 12-26-1967

23c. NAME OF CEMETERY OR CREMATORY: Baltimore National Cem.

23d. LOCATION (City, town or county) (State): Baltimore, Md.

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: George J. Gonce-4001 Ritchie Hgwy., Baltimore

25a. REC'D BY REGISTRAR DATE: DEC 28 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR AIS (4) 20M S-63

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16323 — 16315

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. **PLACE OF DEATH**
   a. COUNTY: Anne Arundel — MARYLAND
   b. CITY OR TOWN (If outside carparate limits, write RURAL and give nearest tawn): Glen Burnie
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 705 Greentree Road

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Anne Arundel
   c. CITY OR TOWN (If outside carparate limits, write RURAL and give nearest town): Glen Burnie
   d. STREET ADDRESS: 705 Greentree Road
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. **NAME OF DECEASED** (Type or print): First: Sophia — Middle: — Last: Coliano

4. **DATE OF DEATH**: Month: December — Day: 30 — Year: 19 67

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 9/12/1898

9. AGE (In years last birthday): 69 yrs.
   IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Haurs / Min.

10a. USUAL OCCUPATION (Give kind af wark dane during mast af working life, even if retired): Homemaker

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (County & State, ar fareign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Luciano Raimondi

14. MOTHER'S MAIDEN NAME: Rose Sylvstri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na, ar unknawn) (If yes give war ar dates af service): No

16. SOCIAL SECURITY NO.:

17. **INFORMANT**: Angelo P. Coliano — Address: (Same)

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter anly ane cause per line far (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Massive acute myocardial infarction
DUE TO (b):
DUE TO (c):
Canditians, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4201
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I ar Part II af item 18.)

20c. TIME OF INJURY Manth, Day, Year Haur a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Nat While at work ☐

20e. PLACE OF INJURY (Hame, farm, factary, street, affice bldg., etc.)

20f. (City ar tawn) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from _____, 19 62 to 12.30, 19 67, that (I) (we) last saw the deceased alive an 12.30. 1967, and that death occurred at _____ M, from causes and on the date stated above.

22a. SIGNATURE: Stanley Ankudas M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 12.67

22c. PHYSICIAN'S NAME (Type): Dr. Stanley Ankudas

22d. ADDRESS: 1101 Maiden Choice Lane

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 1/3/1968

23c. NAME OF CEMETERY OR CREMATORY: Holy Redeemer

23d. LOCATION (City ar Tawn) (County) (State): Baltimore, , Md.

24. FUNERAL DIRECTOR: H. W. Jenkins & Sons Co. — ADDRESS: 4905 York Road 21212

25a. REC'D BY REGISTRAR DATE: JAN 2 1968

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
20 M 1/66

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 7-62

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

16324 16316

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural-Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Holly Pt. Annapolis Roads

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural-Annapolis
d. STREET ADDRESS: Holly Pt. Annapolis Roads
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Jean — Middle: M. — Last: Creighton

4. DATE OF DEATH: Month: Dec. — Day: 11 — Year: 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: Oct. 2, 1883

9. AGE (In years last birthday): 84 yrs.

IF UNDER 1 YEAR: Months: — Days:
IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (County & State or foreign country): Ontario, Canada

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Hugh MacKinnon

14. MOTHER'S MAIDEN NAME: Not Known

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unkown): No
(If yes give wer or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: A. Graham Creighton — Address: #2

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CORONARY THROMBOSIS — INTERVAL BETWEEN ONSET AND DEATH: 10 MINUTES
DUE TO
(b): ARTERIOSCLEROTIC HEART DISEASE — 15 YEARS
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour e.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED — While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from MAY 12, 1966 to DEC 11, 1967, that (I) (we) last saw the deceased alive on Dec 1967, and that death occurred at ..... M, from the causes and on the date stated above.

22a. SIGNATURE: Edward S. Beck M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 12-11-67

22c. PHYSICIAN'S NAME (Type): EDWARD S. BECK

22d. ADDRESS: Franklin St. Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 12-13-67

23c. NAME OF CEMETERY OR CREMATORY: Cedar Grove

23d. LOCATION (City, town or county) (State): New London Conn.

24 FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: John M. Taylor & Sons Annapolis, Md.

25a. REC'D BY REGISTRAR: DEC 14 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16325 — Reg. Dist. No. 16317

1. PLACE OF DEATH
a. COUNTY: Hg Co — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Laurel
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Laurel Race Track

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: MD — b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore — 30-4
d. STREET ADDRESS: 702 Stamford Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Albert — Middle: D — Last: Cummins
4. DATE OF DEATH: Month: 12 — Day: 23 — Year: 1967
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ Separated
8. DATE OF BIRTH: XX 6/28/17
9. AGE (In years last birthday): 50 yrs.
IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman
10b. KIND OF BUSINESS OR INDUSTRY: Chuck Wagon, Inc.
11. BIRTHPLACE (State or foreign country): Balto., Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Late - Albert Cummins
14. MOTHER'S MAIDEN NAME: Late Frances Kosha

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): yes — (If yes, give war or dates of service): WW II
16. SOCIAL SECURITY NO.: 383-18-1273
17. INFORMANT: Melvin Cummins — Address: 203 5th Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac — INTERVAL BETWEEN ONSET AND DEATH: Instan
DUE TO (b): 4344
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour: a.m. / p.m. — Month, Day, Year: 12/23 1967
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Laurel Race
20f. (City or town): Hg Co (County) (State): Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: E. Lin Board M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 12-23-67
EXAMINER'S NAME (Type): E. Lin Board.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12/27/67
22c. NAME OF CEMETERY OR CREMATORY: Baltimore National Cem.
22d. LOCATION (City, town, or county) (State): Baltimore, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Witzke F. D. - 4101 Edmondson Ave.
ADDRESS
24a. RECD BY REGISTRAR DATE: DEC 26 1967
24b. REGISTRAR'S SIGNATURE: Charles Yingling

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

16326 16318

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Arnold, Md.
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 402 NASKELL DRIVE

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MD
b. COUNTY: A A
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ARNOLD, MD
d. STREET ADDRESS: 402 Haskell DR
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Josephine — Middle Dameron — Last
4. DATE OF DEATH: Month Dec. — Day 22 — Year 1967

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 3/16/1913
9. AGE (In years last birthday): 54 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): VA
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Perry MANESS
14. MOTHER'S MAIDEN NAME: Polly —

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO
(If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Family — Address: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Carcinoma of the stomach — INTERVAL BETWEEN ONSET AND DEATH: 1 year
151X
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year / Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Mar. 16, 1964, to Dec. 22, 1967, that (I) (we) last saw the deceased alive on Dec 22 1967, and that death occurred at M, from the causes and on the date stated above.

22a. SIGNATURE: Ray m Smith M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Dec 22, 1967
22c. PHYSICIAN'S NAME (Type): Ray m. Smith, M.D.
22d. ADDRESS: Hahn Professional Bldg., Severna Park Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
23b. DATE THEREOF: 12-22-67
23c. NAME OF CEMETERY OR CREMATORY: Lee Crem.
23d. LOCATION (City, town or county) (State): Wash. D.C.

24. FUNERAL DIRECTOR: John H. Hahn
ADDRESS: 4200 Pennsylvania Ave Baltimore 21226, Md.
25e. REC'D BY REGISTRAR DATE: DEC 26 1967
25b. REGISTRAR'S SIGNATURE: [illegible] Judge

VR A15 (4)
2DM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16327

CERTIFICATE OF DEATH

16319

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 43 Murray Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Theodore — Middle: John — Last: DEMAS

4. DATE OF DEATH: Month: December — Day: 18 — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 18, 1903

9. AGE (In years last birthday): 64 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): self employed

10b. KIND OF BUSINESS OR INDUSTRY: Restaurant

11. BIRTHPLACE (County & State, or foreign country): Greece

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: John Demas

14. MOTHER'S MAIDEN NAME: Evandeline Demas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give wor or dotes of service)

16. SOCIAL SECURITY NO.: 217-32-9144

17. INFORMANT: Chris Demas — Address: 43 Murray Ave. Anna.Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage
DUE TO
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
(b):
DUE TO
(c):
157X
INTERVAL BETWEEN ONSET AND DEATH: Minutes

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 11/6 5, 19__, to 12/18, 19 67, that (I) (we) last saw the deceased alive on 12/18/67 19__, and that death occurred at 12:45 P.M. from causes and on the date stated above.

22a. SIGNATURE: Leonard Church M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 12/19/67

22c. PHYSICIAN'S NAME (Type): Leonard Church

22d. ADDRESS: 121 Eastern Ave St Annapolis Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Dec. 20 1967

23c. NAME OF CEMETERY OR CREMATORY: St. Demetrius Cem.

23d. LOCATION (City or Town) (County) (State): Annapolis, Anne Arundel Md

24. FUNERAL DIRECTOR: Beall Funeral Home — ADDRESS: 1212 West St. Anna. Md.

25a. REC'D BY REGISTRAR DATE: DEC 22 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16328 Item #23b Film #G395-32/11/67 pb

CERTIFICATE OF DEATH

16320

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Annapolis
c. LENGTH OF STAY IN 1b: 2 Years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Southaven Rd.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MD.
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural – Annapolis
d. STREET ADDRESS: Southaven Rd.
e. IS RESIDENCE ON A FARM? YES ☑ NO ☐

3. NAME OF DECEASED (Type or print): First Henry — Middle — Last Di Benio
4. DATE OF DEATH: Month 12 — Day 5 — Year 19 67
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 2/13/11
9. AGE (In years last birthday): 56 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY: Construction
11. BIRTHPLACE (County & State, or foreign country): New York State
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Felix Di Benio
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs Di Benio — Address: As above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH:
443 X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Hypertensive Arteriosclerotic CV Disease — many years
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Obesity
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June, 19 67, to Decem, 19 67, that (I) (we) last saw the deceased alive on 11/25 19 67, and that death occurred at 10A M, from causes and on the date stated above.

22a. SIGNATURE: Robert O. Biern — M.D. ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/5/67
22c. PHYSICIAN'S NAME (Type): Robert O. Biern, M.D.
22d. ADDRESS: 121 Cathedral Street, Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12/7/67
23c. NAME OF CEMETERY OR CREMATORY: Chesterfield Cemetery
23d. LOCATION (City or Town) (County) (State): Centerville Queen Annes Md.

24. FUNERAL DIRECTOR: Hardesty — ADDRESS: Funeral Home, Annapolis Md.
25a. REC'D BY REGISTRAR — DATE: DEC 7 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16329 Item #9 Film #G396 12/27/67 ph

CERTIFICATE OF DEATH

16321

1. **PLACE OF DEATH**
   a. COUNTY: AA
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): North Anne Arundel Amusement Hm

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Md
   b. COUNTY: AA
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Severn
   d. STREET ADDRESS: Camphead Rd 021
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Harry Middle: W Last: Disney

4. **DATE OF DEATH**: Month: 12 Day: 19 Year: 1967

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 12/9/91

9. AGE (In years last birthday): 76 Y 7 M yrs.

IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: State Rds. Comm

11. BIRTHPLACE (County & State, or foreign country): Severn, AA Co., Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George P. Disney

14. MOTHER'S MAIDEN NAME: Ida E. Beasley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service):

16. SOCIAL SECURITY NO.:

17. **INFORMANT**: Chas Disney Address: North Anne Arundel C. C.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Mediastinal Syndrome
DUE TO (b): Carcinoma
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
164 X

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 10/10/67, 19 — to 12/19/67, 19 —, that (I) (we) last saw the deceased alive on 12/15/67 19 —, and that death occurred at 8:30 a.m. M, from causes and on the date stated above.

22a. SIGNATURE: J. B. RAMIREZ M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 12/ /67

22c. PHYSICIAN'S NAME (Type): J. B. Ramirez

22d. ADDRESS: 3527 ANNAPOLIS, MD Balto 27
325 Hospital Drive Glen Burnie

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 22 Dec. 67

23c. NAME OF CEMETERY OR CREMATORY: Sulphur Spring Cem.

23d. LOCATION (City or Town) (County) (State): Ft. Meade, Maryland

24. FUNERAL DIRECTOR: Kirkley Funeral Home, Glen Burnie, Md.

ADDRESS:

25a. REC'D BY REGISTRAR DATE: DEC 22 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16330

CERTIFICATE OF DEATH

16322

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside carporate limits, write RURAL and give neorest town): Annapolis
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): (Dead on arrival) Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside carporate limits, write RURAL ond give neorest town): Lothian
d. STREET ADDRESS: Waysons Restaurant
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Loren — Middle: Charley — Lost: DOTY

4. DATE OF DEATH: Month: December — Day: 27 — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Nov. 4, 1906

9. AGE (In years last birthday): 61 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unk.

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (County & State, or foreign country): Kansas

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Charles Doty

14. MOTHER'S MAIDEN NAME: Anna Bell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Unk. (If yes give war or dates at service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Hospital Records — Address: Annapolis, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: 6 mo.
DUE TO
4341
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Waldenström's Macroglobulinemia

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 6/67, 19__ to 12/27, 19__, that (I) (we) last saw the deceased alive on 12/25 1967, and that death occurred at 9:10 A M, from causes and on the date stated above.

22a. SIGNATURE: Richard N. Peeler M.D. — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 12/27/67

22c. PHYSICIAN'S NAME (Type): Richard N. Peeler, M.D.

22d. ADDRESS: 121 Cathedral St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 12-30-67

23c. NAME OF CEMETERY OR CREMATORY: Graceland Cemetery

23d. LOCATION (City or Town) (County) (State): Madison S. Dakota

24. FUNERAL DIRECTOR: John M. Taylor & Sons — ADDRESS: Annapolis, Md.

25a. REC'D BY REGISTRAR DATE: DEC 29 1967

25b. REGISTRAR'S SIGNATURE: Charles Jaggard

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

16331 — 16323

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b: 1 month
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): N. Arundel Convel. Center

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore — 30.X
d. STREET ADDRESS: 3662 Keswick Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First SARA — Middle C. — Last DOWNEY

4. DATE OF DEATH: Month 12 — Day 28 — Year 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 10 18 1911

9. AGE (In years last birthday): 56 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic Worker

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: HARRY Musgrove

14. MOTHER'S MAIDEN NAME: LAURA

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: John H Downey — Address: Glen Burnie

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Retroperitoneal tumor
230X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerotic heart disease
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 11/18/, 1967, to 12/28/, 1967, that (I) (we) last saw the deceased alive on 12/28/ 1967, and that death occurred at 12:30 M, from the causes and on the date stated above.

22a. SIGNATURE: Edmond J. Moushabek — M.O. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 12/29/67

22c. PHYSICIAN'S NAME (Type): EDMOND J. MOUSHABEK

22d. ADDRESS: 510 MARLEY STATION ROAD GLEN BURNIE, Md 21061

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 12-30-67

23c. NAME OF CEMETERY OR CREMATORY: Mays Chapel

23d. LOCATION (City, town or county) (State): Balto Co Md

24. FUNERAL DIRECTOR: Burgee Funeral Home — ADDRESS: Balto Md

25a. REC'D BY REGISTRAR DATE: JAN 2 1968

25b. REGISTRAR'S SIGNATURE: Charles Judge

By Horace M Burgee Jr

VR A15 (4)
2DM 1-65

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16332

CERTIFICATE OF DEATH

16324

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (-)
20 M 1/64

1. PLACE OF DEATH
   a. COUNTY: Anne Arundel — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
   c. LENGTH OF STAY IN 1b: 6 hours
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): North Arundel Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Anne Arundel
   c. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town): Severna Park 02-1
   d. STREET ADDRESS: 855 Cottonwood Drive
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Eva — Middle: L. — Lost: Drankwicz

4. DATE OF DEATH: Month: December — Doy: 28 — Year: 1967

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 10-19-03

9. AGE (In years last birthday): 64 yrs.
   IF UNDER 1 YEAR: Months / Doys
   IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY: @ home

11. BIRTHPLACE (County & State, or foreign country): Mississippi

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Michael Wenerski

14. MOTHER'S MAIDEN NAME: Theodore Crown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Mrs. Regina Loy-Above — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): Acute Left Ventricular Failure — INTERVAL BETWEEN ONSET AND DEATH: Hours
   DUE TO (b): Essential Hypertension — 7 to 10 yrs
   Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
   443X

   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Doy, Yeor Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 12-25, 1967 to 12-25, 1967, that (I) (we) last saw the deceased alive on 12-25 1967, and that death occurred at 6:30 P.M., from causes and on the date stated above.

22a. SIGNATURE: Hilary T. O'Herlihy M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 12-28-67

22c. PHYSICIAN'S NAME (Type): Hiliary T. O'Herlihy

22d. ADDRESS: Medical Center-Hospital Drive-Glen Burn

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 12/30/67

23c. NAME OF CEMETERY OR CREMATORY: Glen Haven

23d. LOCATION (City or Town) (County) (State): Glen Burnie Md

24. FUNERAL DIRECTOR: Albert S. Banaard — ADDRESS: Severna Pk Md

25a. REC'D BY REGISTRAR DATE: JAN 2 1968

25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16333

CERTIFICATE OF DEATH

16325

1. **PLACE OF DEATH**
   a. COUNTY: Anne Arundel — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): Naval Hospital

2. **USUAL RESIDENCE** (Where deceosed lived, if institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Anne Arundel
   c. CITY OR TOWN (If outside corparate limits, write RURAL and give nearest town): Glen Burnie
   d. STREET ADDRESS: Annapolis, Md.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First JOHN — Middle ADAM — Lost DRUMM, JR.

4. **DATE OF DEATH**: Month December — Doy 13 — Year 19 67

5. SEX: Male

6. COLOR OR RACE: Cauc.

7. MARRIED ☒ — NEVER MARRIED ☐ — WIDOWED ☐ — DIVORCED ☐

8. DATE OF BIRTH: 26 August 1926

9. AGE (In yeors lost birthday): 41 yrs.

IF UNDER 1 YEAR: Months / Doys — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): R.F.C.

10b. KIND OF BUSINESS OR INDUSTRY: MD. NAT'L. GAURD

11. BIRTHPLACE (County & Stote, or foreign country): BALTIMORE, MARYLAND

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: JOHN A. DRUMM, SR.

14. MOTHER'S MAIDEN NAME: FRANCES LOUISE CLARK

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES (If yes give war or dotes of service): WW II

16. SOCIAL SECURITY NO.: 216 20 0119

17. **INFORMANT** Address: MRS. HILDEGARDE A. DRUMM (WIFE) SAME AS #2

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (o), (b), and (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (o): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH
   4201
   Conditions, if ony, which gave rise to immediate couse (o), stoting the underlying couse lost.
   DUE TO (b): Arteriosclerotic Heart Disease
   DUE TO (c): Ventricular Fibrillation

   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 10 Dec., 19 67 to 13 Dec., 1967, that (I) (we) last saw the deceased alive on 13 Dec. 19 67, and that death accurred at 1130 A M, fram causes and an the date stated above.

22a. SIGNATURE: B J Coughlin — M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): B. J. COUGHLIN, LT MC USNR

22d. ADDRESS: NAVAL HOSPITAL, ANNAPOLIS, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: DEC. 18/67

23c. NAME OF CEMETERY OR CREMATORY: GLEN HAVEN MEMORIAL PARK

23d. LOCATION (City or Town) (County) (State): GLEN BURNIE, MARYLAND

24. FUNERAL DIRECTOR: SINGLETON FUNERAL HOME — ADDRESS: CRAIN & RITCHIE HWY, GLEN BURNIE, MD.

25a. REC'D BY REGISTRAR DATE DEC 19 1967

25b. REGISTRAR'S SIGNATURE: J Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

16334

CERTIFICATE OF DEATH

16326

1. PLACE OF DEATH
   a. COUNTY: Anne Arundel — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Glen Burnie
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 2107 Dorsey Road

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Anne Arundel
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
   d. STREET ADDRESS: 2107 Dorsey Road 21061
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Lizzie — Middle: E. — Last: Durham

4. DATE OF DEATH: Month: December — Day: 4, — Year: 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Aug. 14, 1871

9. AGE (In years last birthday): 96 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Six Mile South Carolina

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: ?

14. MOTHER'S MAIDEN NAME: Garrett

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No

(If yes give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Mr. Earl Griffin 2107 Dorsey Road 21061

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebro-vascular accident — INTERVAL BETWEEN ONSET AND DEATH: 3 days
4221
DUE TO (b): A. S. C. V. D.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1963, 19___, to Dec. 4, 1967, that (I) (we) last saw the deceased alive on Dec. 4 1967, and that death occurred at 8 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Robert Dabolins — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 12-5-67

22c. PHYSICIAN'S NAME (Type): Robert Dabolins M.D.

22d. ADDRESS: 400 Crain Hwy N.W.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 12/7/67

23c. NAME OF CEMETERY OR CREMATORY: Six Mile Baptist Cemetery

23d. LOCATION (City, town or county) (State): Six Mile, S.C.

24. FUNERAL DIRECTOR: McCulley Funeral Home — ADDRESS: 237 Patapsco Ave. 21225

25a. REC'D BY REGISTRAR — DATE: DEC 6 1967

25b. REGISTRAR'S SIGNATURE: J Charles Judge

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16335 Item #3 Film #G396 1/3768 ph

CERTIFICATE OF DEATH

16327

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): North Arundel Convalescent Center

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
d. STREET ADDRESS: 116 Carroll Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First [illegible] Middle Roy — Last Ellis

4. DATE OF DEATH: Month 12 — Day 27 — Year 1967

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: Dec 1 1882

9. AGE (In years last birthday): 85 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Repairman (Ret.)

10b. KIND OF BUSINESS OR INDUSTRY: C & P Telephone Co

11. BIRTHPLACE (County & State, or foreign country): Baltimore, Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John E. Ellis

14. MOTHER'S MAIDEN NAME: Mollie Sherwood

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): None

16. SOCIAL SECURITY NO.: 212-10-0773A

17. INFORMANT: Mr Charles L. Ellis (Nephew) — Address: 24 Love Lane Norwood, Penna

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 48 hrs.
DUE TO (b): Arteriosclerotic heart disease
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from October, 1959, to Dec., 1967 that (I) (~~we~~) last saw the deceased alive on 12-27 1967, and that death occurred at 12:10 A M, from causes and on the date stated above.

22a. SIGNATURE: Edmund I. Moushabek M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): EDMOND I. MOUSHABEK

22d. ADDRESS: 510 Harley Station Road Glen Burnie, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Dec 30 1967

23c. NAME OF CEMETERY OR CREMATORY: Woodlawn Cemetery

23d. LOCATION (City or Town) (County) (State): Baltimore, Md

24. FUNERAL DIRECTOR: Singleton Funeral Home — ADDRESS: E. B. Fleming Glen Burnie, Md

25a. REC'D BY REGISTRAR DATE: DEC 28 1967

25b. REGISTRAR'S SIGNATURE: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16336 Item 9 Film G396 1/2768 kk

CERTIFICATE OF DEATH

16328

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Ann Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b: 1 Day
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): North Arundel Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Ann Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Severn, Md. 021
d. STREET ADDRESS: 313 Queestown Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Fred — Middle: — Last: Evans

4. DATE OF DEATH: Month: 12-14 — Day — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 9-14-95

9. AGE (In years last birthday): 72 76 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ~~Retired~~ Retired

10b. KIND OF BUSINESS OR INDUSTRY: CONSTRUCTION

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ISAIAH FUMNS

14. MOTHER'S MAIDEN NAME: ELLA BRACKSTON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes give wor or dates of service)

16. SOCIAL SECURITY NO.: 214-05-2971

17. INFORMANT — Address: MARIE PARKER - SEVERN MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 15 hrs.
DUE TO
(b): A. S. C. V. D.
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying couse last.

4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Dec. 13, 1967, to Dec. 14, 1967, that (I) (we) last saw the deceased alive an Dec 14 1967, and that death occurred at 430 M, from causes and on the date stated above.

22a. SIGNATURE: Robert Dabolins — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: Dec. 14, 1967

22c. PHYSICIAN'S NAME (Type): ROBERT DABOLINS M.D.

22d. ADDRESS: 400 CRAIN Hwy N.W GLEN BURNIE MD

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

23b. DATE THEREOF: 12-16-67

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City or Town) (County) (State)

24. FUNERAL DIRECTOR: Hamburger & Hayes — ADDRESS: 636 N Gilmor St

25a. REC'D BY REGISTRAR — DATE: DEC 19 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16337 Item #4 per telephone conv. w/ Hahn Funeral Homeph

CERTIFICATE OF DEATH

16329

1. PLACE OF DEATH
a. COUNTY: AA
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Brookly Park
c. LENGTH OF STAY IN 1b: YRS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 210 Holy Cross Road

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MD.
b. COUNTY: AA
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BROOKLYN PARK 02-1
d. STREET ADDRESS: 210 Holy Cross Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ROY Middle W. Lost EVANS

4. DATE OF DEATH: Month 12 - Doy 29 Year 19 67

5. SEX: M

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: OCT. 9, 1916

9. AGE (In years last birthday): 51 yrs.

IF UNDER 1 YEAR: Months / Doys
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): TRUCK Driver

10b. KIND OF BUSINESS OR INDUSTRY: Macy - Turnbull Co

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Lawrence Evans

14. MOTHER'S MAIDEN NAME: Sarah —

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES (If yes give wor or dotes of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: FAMILY Address: Home

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of the Pancreas with 157X
DUE TO (b): Metastasis to Liver.
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from July 3, 1967, to Dec. 29, 1967, that (I) (we) last saw the deceased alive an Dec 29 1967, and that death occurred at 12:15 A M, from causes and on the date stated above.

22a. SIGNATURE: Morton M Krieger M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: Dec 29, 1967

22c. PHYSICIAN'S NAME (Type): Morton M. Krieger, M.D.

22d. ADDRESS: 615 Hammonds Lane Balto. Md. 21225

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 1-2-68

23c. NAME OF CEMETERY OR CREMATORY: Bo Ho. Nat. Cem.

23d. LOCATION (City or Town) (County) (State): Bo Ho 21229, Md.

24. FUNERAL DIRECTOR ADDRESS: John H. Hahn Funeral Home - 4200 Pennington Ave 21226

25a. REC'D BY REGISTRAR DATE: JAN 2 1968

25b. REGISTRAR'S SIGNATURE: Charles Griffin

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16338

CERTIFICATE OF DEATH

16330

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. **PLACE OF DEATH**
   a. COUNTY: Ann Arundel — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
   c. LENGTH OF STAY IN 1b: 14 DAYS
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): North Arundel Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Md. — b. COUNTY: Baltimore City
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
   d. STREET ADDRESS: 4402 Fairhaven Ave. Curtis Bay
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Marie (MARYANN) — Middle: H. — Last: Faby

4. **DATE OF DEATH**: Month: 12 — Day: 19 — Year: 19 67

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ — NEVER MARRIED ☐ — WIDOWED ☒ — DIVORCED ☐

8. DATE OF BIRTH: 3-21-20

9. AGE (In years last birthday): 47 yrs.

IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY: HOME

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: KONSTANLEY ALEKSALZA

14. MOTHER'S MAIDEN NAME: MARYANN MALINOWSKI

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes give war or dates of service): —

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: EDW. FABY — Address: 4402 FAIRHAVEN AVE. 21206

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Renal Failure — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO (b): Cirrhosis Liver
DUE TO (c): —
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
5810

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 12-5, 19 67, to 12-19, 19 67, that (I) (we) last saw the deceased alive on 12-18-67 19, and that death occurred at 7:00 M, from causes and on the date stated above.

22a. SIGNATURE: Charles R. MacDonald M.D. — ATTENDING PHYS. ☒ — MED. DIRECTOR ☐ — STAFF PHYS. ☐

22b. DATE SIGNED: 12-19-67

22c. PHYSICIAN'S NAME (Type): Charles R. MacDonald M.D.

22d. ADDRESS: 325 Hospital Drive Glen Burnie, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 12-23-67

23c. NAME OF CEMETERY OR CREMATORY: HOLY CROSS CEM.

23d. LOCATION (City or Town) (County) (State): BALTO. ANNE ARUNDEL, MD.

24. FUNERAL DIRECTOR: W. FIALKOWSKI — ADDRESS: 2007 EASTERN AVE. BALTO., MD. 21231

25a. REC'D BY REGISTRAR DATE: DEC 22 1967

25b. REGISTRAR'S SIGNATURE: Richard Jaeger

Wm. Fialkowski

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16339

CERTIFICATE OF DEATH

16331

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
   a. COUNTY: Ann Arundel — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
   c. LENGTH OF STAY IN 1b: 8 Days
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): North Arundel Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Balto. County
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore XXXX XXXX (Brooklyn Park) 02-1
   d. STREET ADDRESS: 601 Holy Cross Rd.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Wald● (Mmi) Middle: Lost: Fletcher

4. DATE OF DEATH: Month 12- Day 25 Year 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 5-29-94

9. AGE (In years last birthday): 73 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired (Pipe-Fitter)

10b. KIND OF BUSINESS OR INDUSTRY: B&O Railroad

11. BIRTHPLACE (County & State, or foreign country): West Virginia (Grafton)

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Fletcher

14. MOTHER'S MAIDEN NAME: (Unknown)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service): None

16. SOCIAL SECURITY NO.: 705-03-9577

17. INFORMANT: Mrs. Anna M. Fletcher (wife) Address: Same as #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 1 week
DUE TO
(b): ASCVHD — 4 years
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from _____, 19___, to _____, 19___, that (I) (we) last saw the deceased alive on _____ 19___, and that death occurred at 12:45 M, from causes and on the date stated above.

22a. SIGNATURE: Paul Thomson M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Dec. 28, 1967

23c. NAME OF CEMETERY OR CREMATORY: Loudon Park Cemetery

23d. LOCATION (City or Town) (County) (State): Baltimore, Md.

24. FUNERAL DIRECTOR: E. B. Fleming ADDRESS: Singleton Funeral Home Glen Burnie, Md.

25a. RECD BY REGISTRAR DATE: DEC 27 1967

25b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16340

CERTIFICATE OF DEATH

16332

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — Annapolis MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
c. LENGTH OF STAY IN 1b: 8 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Naval Hospital, Annapolis, Md.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
d. STREET ADDRESS: 702 Tyler Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ella — Middle: Mae — Last: Fogg

4. DATE OF DEATH: Month: 12 — Day: 18 — Year: 19 67

5. SEX: Female

6. COLOR OR RACE: Cauc.

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct 8 1919

9. AGE (In years last birthday): 48 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE

10b. KIND OF BUSINESS OR INDUSTRY: HOME

11. BIRTHPLACE (County & State, or foreign country): Philadelphia, Pa.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: James P. Crawford

14. MOTHER'S MAIDEN NAME: Agnes Carney

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: FRANK M. FOGG — Address: # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinomatosis
DUE TO
(b): Carcinoma breast
DUE TO
(c):

170 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from _____, 19___, to _____, 19___, that (I) (we) last saw the deceased alive on 18 December 1967, and that death occurred at 1859 M, from causes and on the date stated above.

22a. SIGNATURE: A. C. J. Brickel
M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 12/19/67

22c. PHYSICIAN'S NAME (Type): A. C. J. BRICKEL, LT MC USNR

22d. ADDRESS: NAVAL HOSPITAL, ANNAPOLIS, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 12/22/67

23c. NAME OF CEMETERY OR CREMATORY: ST. MARY'S CEM.

23d. LOCATION (City or Town) (County) (State): ANNAPOLIS MD.

24. FUNERAL DIRECTOR: JOHN M. TAYLOR & SONS, ANNAPOLIS, MD.

ADDRESS:

25a. REC'D BY REGISTRAR DATE: DEC 21 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form HD 343. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16341

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16333

1. PLACE OF DEATH
   a. COUNTY: A.A. Co. — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Minor Rd.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
   a. STATE: MD — b. COUNTY: AACO
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Arden-on-Severn
   d. STREET ADDRESS: Plum Dr + Minor Road
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Phillip — Middle: G. — Last: Fogler

4. DATE OF DEATH: Month: 12 — Day: 30 — Year: 1967

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 30, 1953

9. AGE (In years last birthday): 14 yrs.
   IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student

10b. KIND OF BUSINESS OR INDUSTRY: School

11. BIRTHPLACE (State or foreign country): Balto. Md.

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: John W. Fogler

14. MOTHER'S MAIDEN NAME: Lorraine E. Schaefer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
   (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Lorraine E. Fogler — Address: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): Gun Shot Wound - Skull
   DUE TO (b):
   DUE TO (c):
   Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
   INTERVAL BETWEEN ONSET AND DEATH: Instant

   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Gun Shot Wound Skull - Accidental

20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m.: 12/30 1967

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town): AACO (County): MD (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: [signature] M.D.

EXAMINER'S NAME (Type): E. Linhardt

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):

22. DATE SIGNED: 12/30/67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 1 3 1967

23c. NAME OF CEMETERY OR CREMATORY: Glen Haven

23d. LOCATION (City or Town) (County) (State): Glen Burnie, A. A. Co. Md.

24. FUNERAL DIRECTOR: Mc Cully — ADDRESS: 130 E. Fort Ave

25a. REC'D BY REGISTRAR DATE: JAN 3 1968

25b. REGISTRAR'S SIGNATURE: [signature]

VR A15ME (5) 6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

16342 — 16334

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: Davison	Middle: F.	Last: Gallagher	2a. DATE OF DEATH Month: 12 Day: 25 Year: 67	2b. HOUR: 8:25PM
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: 9/24/91	6. AGE (In years last birthday): 76 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (State or foreign country): Pennsylvania	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: Anne Arundel		Md.
10. CITY OR TOWN OF DEATH: Crownsville	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Crownsville State Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Construction Work	12b. KIND OF BUSINESS OR INDUSTRY: ----------		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland	13b. COUNTY: A. A.	13c. CITY OR TOWN: Baltimore	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET AND NUMBER: 1181/2 Camrose Street	
14. FATHER'S NAME First: Hugh	Middle:	Last: Gallagher	15. MOTHER'S MAIDEN NAME First: Marry	Middle:	Last: Stewart
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: no	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 216-03-0827	17. INFORMANT Address: Hospital Records, Crownsville State Hospita		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Pneumonia — 493x — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Chronic Brain Syndrome ; Generalized arteriosclerosis

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from 12/5, 19 67, to 12/25, 19 67, that (I) (we) last saw the deceased alive on 12/25/ 19 67, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS. [ ]	MED. DIRECTOR [X]	STAFF PHYS. [ ]	22c. DATE SIGNED: 12/26/67
22d. PHYSICIAN'S NAME (Type): L. Benedict, M.D.			22e. ADDRESS: Crownsville State Hospital, Maryland		

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 12-29-1967	23c. NAME OF CEMETERY OR CREMATORY: Loudon Park Cemetery	23d. LOCATION (City or Town) (County) (State): Baltimore, Maryland

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
George J. Gonce	4001 Ritchie Hgwy., Baltimore	DEC 29 1967	James Yaeger

VR A15 (4) 30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16343

CERTIFICATE OF DEATH

16335

1. **PLACE OF DEATH**
   a. COUNTY: Anne Arundel — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Anne Arundel
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis 02.1
   d. STREET ADDRESS: 1 Shipwright St.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First — Middle — Last: GAY

4. **DATE OF DEATH**: Month: December — Day: 24 — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: December 24, 1967

9. AGE (In years last birthday) yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours 1½ / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Annapolis, Maryland

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Arnold C. GAY

14. MOTHER'S MAIDEN NAME: Julia Wilson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown):
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: A.C. GAY — Address: #2

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Respiratory Failure
DUE TO
(b): Prematurity
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
7735

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from _____, 19___, to _____, 19___, that (I) (we) last saw the deceased alive on _____ 19___, and that death occurred at 2:30 P.M. from causes and on the date stated above.

22a. SIGNATURE: James E Wheeler

M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 12-26-67

22c. PHYSICIAN'S NAME (Type): James E. Wheeler, M.D.

22d. ADDRESS: 308 S. Cherry Grove Ave., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): CREMATION

23b. DATE THEREOF: 12-27-67

23c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln

23d. LOCATION (City or Town) (County) (State): BLADENSBURG MD.

24. FUNERAL DIRECTOR: John M. Lafferty & Sons — ADDRESS: Annapolis, Md.

25a. REC'D BY REGISTRAR DATE: DEC 29 1967

25b. REGISTRAR'S SIGNATURE: Richard Yeager

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16344

CERTIFICATE OF DEATH

16336

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH a. COUNTY: Anne Arundel — MARYLAND	**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission) a. STATE: Maryland — b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville — c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Crownsville State Hospital	d. STREET ADDRESS: 31 College Creek Avenue — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Hattie		Green	12	18	1967

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
F	N		7/29/91	76 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
retired	----------	Maryland	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Thomas Butler	Kate (?) Butler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
no	213-28-9924	Hospital Records, Crownsville Maryland

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral vascular accident — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(b): Hypertension
DUE TO
(c): Generalized arteriosclerosis

331X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Pyelitis chronic brain syndrome

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 11/18, 1967, to 12/18, 1967, that (I) (we) last saw the deceased alive on 12/18 1967, and that death occurred at 1:30 M, from causes and on the date stated above.

22a. SIGNATURE	M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☒ STAFF PHYS. ☐	22b. DATE SIGNED
[signature]		12/18/67

22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS
Ludwig, Benedict, M.D.	Crownsville, State Hospital, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	12/21/67	Broadneck	St. Margarets A.A. Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Wm REESE II 108 N. WASHINGTON St	DEC 20 1967	J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16345

CERTIFICATE OF DEATH

16337

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH a. COUNTY: Ann Arundel — MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie c. LENGTH OF STAY IN 1b: d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): North Arundel Hospital	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: Maryland — b. COUNTY: Ann Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pasadena d. STREET ADDRESS: Rt. 4 Box 14 - Greenhaven e. IS RESIDENCE ON A FARM? YES ☐ NO ☒
3. NAME OF DECEASED (Type or print): First Mabel — Middle R. — Last Grimes	4. DATE OF DEATH: Month 12-26 — Day — Year 19 67
5. SEX: Female	6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH: 6-20-97
9. AGE (In years last birthday): 70 yrs.	IF UNDER 1 YEAR: Months — Days; IF UNDER 24 HRS.: Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife	10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Baltimore, Md.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Vincent Tomlinson	14. MOTHER'S MAIDEN NAME: Susan Hewitt
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)	16. SOCIAL SECURITY NO. 215-32-8170
17. INFORMANT — Address: Mrs. Anna Evered - Rt. 4, Box 14, Pasadena	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 10 days
DUE TO (b): Arteriosclerotic Heart Disease — 4 yrs
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Diabetes Mellitus

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify thot (I) (this hospital) attended the deceased from _____, 19__, to 12-26, 1967, thot (I) (we) last saw the deceased alive on 12-25 — 1967, and thot death occurred at 2:50 PM, from couses and on the dote stoted above.

22a. SIGNATURE: Arley Markley M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 12-26-67

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE THEREOF: Dec. 29, 1967	23c. NAME OF CEMETERY OR CREMATORY: Glen Haven Memorial Pk.	23d. LOCATION (City or Town) (County) (State): Ritchie Hgwy., A.A.Co., Md.
24. FUNERAL DIRECTOR — ADDRESS: George J. Gonce-4001 Ritchie Hgwy., Baltimore		25a. REC'D BY REGISTRAR DATE: DEC 29 1967	25b. REGISTRAR'S SIGNATURE: [illegible]

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

16346 16338

1. PLACE OF DEATH
a. COUNTY: Anne Arundel Co. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie Md.
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Plaza Manor Nursing Home

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 818 Spa Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Charles Middle: Edward Last: Hall

4. DATE OF DEATH: Month: 12 Day: 20th Year: 1967

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 4-18-1905

9. AGE (In years last birthday): 62 yrs.

IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Porter

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Anne Arundel Co. Annapolis

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: Hall Porter

14. MOTHER'S MAIDEN NAME: Peters, Sarah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or detes of service): No

16. SOCIAL SECURITY NO.: 217-16-4239

17. INFORMANT: Blanche A. Hall Address: 818 Spa Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY; IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 10s

DUE TO (b): Cirrhosis of Liver — Unknown

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Arteria Sclerosis — Unknown

4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 10-26, 1967, to 12-20, 1967 that (I) (we) last saw the deceased alive on 12-20 1967, and that death occurred at 9:40 AM, from the causes and on the date stated above.

22a. SIGNATURE: Richard H. Hunt M.D.

22b. DATE SIGNED

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22c. PHYSICIAN'S NAME (Type): Richard H. Hunt

22d. ADDRESS: 102 Cherry Lane, Glen Burnie, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 12-23-1967

23c. NAME OF CEMETERY OR CREMATORY: Brewer Hill

23d. LOCATION (City, town or county) (State): Annapolis Md

24. FUNERAL DIRECTOR'S SIGNATURE: William Bozett ADDRESS: Anna Md

25a. REC'D BY REGISTRAR DATE: DEC 27 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 M
20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16347

CERTIFICATE OF DEATH

16339

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (1)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 9 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL - Bristol
d. STREET ADDRESS: Rt-416
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Frank — Middle: Edward — Last: HALL, Sr.

4. DATE OF DEATH: Month: December — Day: 28 — Year: 1967

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 1, 1895

9. AGE (In years last birthday): 72 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Albert Hall

14. MOTHER'S MAIDEN NAME: Mary Hall

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or Unknown): No (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 579-40-3115?

17. INFORMANT: Mary Hall — Address: Lothian, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cancer of right lung
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
163X
INTERVAL BETWEEN ONSET AND DEATH: One year

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~has inquired~~) attended the deceased from June, 1967, to Dec. 28, 1967, that (I) (~~did~~) last saw the deceased alive on Dec. 28, 1967, and that death occurred at 7:50 PM, from causes and on the date stated above.

22a. SIGNATURE: Charles H. Wirth M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 12/30/67

22c. PHYSICIAN'S NAME (Type): Charles H. Wirth, M.D.

22d. ADDRESS: Portland Place, Lothian, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 12/31/67

23c. NAME OF CEMETERY OR CREMATORY: Adams

23d. LOCATION (City or Town) (County) (State): Bayard, Md.

24. FUNERAL DIRECTOR: William Feese, II — ADDRESS: Annq. Md.

25a. REC'D BY REGISTRAR DATE: JAN 2 1968

25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16348

CERTIFICATE OF DEATH

16340

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 15 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): 916 Central

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis, 02.1
d. STREET ADDRESS: 916 Central
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William — Middle: NMN — Last: Harris or Harrod
4. DATE OF DEATH: Month: December — Day: 10 — Year: 19 67

5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 2-21-1881
9. AGE (In years last birthday): 86 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cook
10b. KIND OF BUSINESS OR INDUSTRY: Naval Academy
11. BIRTHPLACE (County & State, or foreign country): Anne Arundel, Md
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Wesley Harris
14. MOTHER'S MAIDEN NAME: Sarah J. Reid

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give wor or dotes of service): ******
16. SOCIAL SECURITY NO.: 220-24-8169
17. INFORMANT: Mary E. Swann Harris — Address: Annapolis, Md 916 Central

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Debility, Generalized — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b): metastatic Ca of liver — 2 yrs
DUE TO (c): Prostatic Cancer — 15 yrs.
177X
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Chronic Pyelonephritis, Chronic Brain Syndrome.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from SEPT. 28, 1967, to DEC. 10, 1967, that (I) (~~saw~~) last saw the deceased alive an DEC. 9, 1967, and that death occurred at 7:30 A.M., from causes and on the date stated above.

22a. SIGNATURE: Richard E. Cook, M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/10/67
22c. PHYSICIAN'S NAME (Type): RICHARD E. COOK, M.D.
22d. ADDRESS: 20 DEAN STREET, ANNAP., Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12-13-67
23c. NAME OF CEMETERY OR CREMATORY: Brewer Hill
23d. LOCATION (City or Town) (County) (State): Annapolis A.A.Co Md

24. FUNERAL DIRECTOR: C.E. Hicks, III — ADDRESS: Annapolis, Maryland
25a. REC'D BY REGISTRAR DATE: DEC 14 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16349 16341

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 20 Thompson St., 021
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Ethel — Middle LARZELERE — Last HERRIES
4. DATE OF DEATH: Month December — Day 5 — Year 19 67
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Jan. 15, 1886
9. AGE (In years last birthday): 81 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOMEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: HOME
11. BIRTHPLACE (County & State, or foreign country): Bluff Pt. New York
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: HERMAN LARZELERE
14. MOTHER'S MAIDEN NAME: MARY WHITNEY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: J. WHITNEY HERRIES — Address #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Thrombosis, Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 10 years
4200
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): ANEMIA, UREMIA
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) ~~(this doctor)~~ attended the deceased from 1 DEC, 19 67 to Dec. 5, 19 67 that (I) ~~(we)~~ last saw the deceased alive an Dec. 5, 19 67, and that death occurred at 2:30 P.M. from causes and on the date stoted abave.

22a. SIGNATURE: Edward S Beck M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12-6-67
22c. PHYSICIAN'S NAME (Type): Edward S. Beck, M.D.
22d. ADDRESS: 73 Franklin St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 12-8-67
23c. NAME OF CEMETERY OR CREMATORY: Hillcrest
23d. LOCATION (City or Town) (County) (State): ANNAPOLIS AA. MD.

24. FUNERAL DIRECTOR: John M. Taylor & Sons — ADDRESS: Annapolis, Md.
25a. REC'D BY REGISTRAR DATE: DEC 8 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16350

CERTIFICATE OF DEATH

16342

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 146 Monticello Ave., 82-1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: James — Middle: Robert — Last: HERRON
4. DATE OF DEATH: Month: December — Day: 20 — Year: 19 67
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 3, 1898
9. AGE (In years last birthday): 69 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NAVAL ENGINEER
10b. KIND OF BUSINESS OR INDUSTRY: Civil SERVICE
11. BIRTHPLACE (County & State, or foreign country): LAURINBURG North Carolina
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: ALEXANDER HERRON
14. MOTHER'S MAIDEN NAME: LUCY ABERNETHY
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES (If yes give war or dates of service): WW I
16. SOCIAL SECURITY NO.: 257 10 9105
17. INFORMANT (Address): CORNELIA C. HERRON #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Peritonitis, diffuse, extensive — INTERVAL BETWEEN ONSET AND DEATH: 20 days
DUE TO
(b): Post-operative ileus and infection — 26 days
DUE TO
(c): Primary Carcinoma of Rectum — 30 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
1530

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Secondary anemia and malnutrition

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this physician) attended the deceased from Nov. 15, 1967, to Dec. 20, 1967, that (I) saw the deceased alive on Dec. 20 1967, and that death occurred at 9:00 AM, from causes and on the date stated above.

22a. SIGNATURE: Merton T. Waite, M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12-20-67
22c. PHYSICIAN'S NAME (Type): Merton T. Waite, M.D.
22d. ADDRESS: 121 Cathedral St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12-23-67
23c. NAME OF CEMETERY OR CREMATORY: ELMWOOD
23d. LOCATION (City or Town) (County) (State): CHARLOTTE N.C.
24. FUNERAL DIRECTOR: John M. Taylor & Sons — ADDRESS: Annapolis, Md.
25a. REC'D BY REGISTRAR DATE: DEC 26 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16351

CERTIFICATE OF DEATH

16343

1. **PLACE OF DEATH**
   a. COUNTY: Anne Arundel — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Anne Arundel
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis 02-1
   d. STREET ADDRESS: 161 Main Street
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Walter — Middle: A. — Last: HIPKINS

4. **DATE OF DEATH**: Month: December — Day: 31 — Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: October 1, 1893

9. AGE (In years last birthday): 74 yrs.
   IF UNDER 1 YEAR: Months / Days
   IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CLERK MET.

10b. KIND OF BUSINESS OR INDUSTRY: RETAIL PAINT

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: JOHN C. HIPKINS

14. MOTHER'S MAIDEN NAME: ELIZABETH BROOKS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes give war or dates of service)

16. SOCIAL SECURITY NO.:

17. **INFORMANT**: MRS. HELEN I. FORD — Address: 4514 Tuckerman St. Riverdale Md

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH: 12 Hours
DUE TO
(b): Arteriosclerotic Heart Disease — 15 YEARS
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4200

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Pulmonary Fibrosis & Emphysema — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) ~~this hospital~~ attended the deceased from JUNE, 1958, to Dec. 31, 1967, that (I) ~~saw~~ last saw the deceased alive on 31 DEC 1967, and that death occurred at 4:40 pm M, from causes and on the date stated above.

22a. SIGNATURE: Edward S Beck M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 12-31-67

22c. PHYSICIAN'S NAME (Type): Edward S. Beck, M.D.

22d. ADDRESS: 73 Franklin Street, Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 1-3-1968

23c. NAME OF CEMETERY OR CREMATORY: ST. ANNE'S CEM.

23d. LOCATION (City or Town) (County) (State): ANNAPOLIS MD

24. FUNERAL DIRECTOR: JOHN M. TAYLOR SON — ADDRESS: ANNAPOLIS MD

25a. REC'D BY REGISTRAR DATE: JAN 4 1968

25b. REGISTRAR'S SIGNATURE: Miranda Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16352 Item #7 Film #G395 12/20/67 ph

CERTIFICATE OF DEATH

16344

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): North Arundel Convalescent Center

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 47 Cathedral
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: MATTIE — Middle: E — Last: HOLT

4. DATE OF DEATH: Month: Dec — Day: 11 — Year: 19 67

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 3-19-1883

9. AGE (In years last birthday): 84 yrs.

IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Wesley Holt

14. MOTHER'S MAIDEN NAME: Rebecca Holt

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Leroy Evans — Address: Annapolis Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Left Ventricular Failure — INTERVAL BETWEEN ONSET AND DEATH: Years
DUE TO (b): Cerebro Vascular accident — Months
DUE TO (c): Generalized Arteriosclerosis — Years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
331X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 9/29, 19 67, to 12/11, 19 67, that (I) (we) last saw the deceased alive on 12/11 19 67, and that death occurred at 7:10 P.M., from causes and on the date stated above.

22a. SIGNATURE: Max C Frantz — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 12/11/67

22c. PHYSICIAN'S NAME (Type): MAX C FRANTZ

22d. ADDRESS: 425 SE Ritchie Hwy Glen Burnie 21061

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 12-15-67

23c. NAME OF CEMETERY OR CREMATORY: Brewer Hill

23d. LOCATION (City or Town) (County) (State): Annapolis Md.

24. FUNERAL DIRECTOR: William Reese — ADDRESS: Anna. Md.

25a. REC'D BY REGISTRAR DATE: DEC 13 1967

25b. REGISTRAR'S SIGNATURE: Charles Jones

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16353

CERTIFICATE OF DEATH

16345

1. PLACE OF DEATH
a. COUNTY: A. A. Co. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 1 Year
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): 650 Americana Drive

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md
b. COUNTY: A. A. Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 650 Americana Dr
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William — Middle: A. — Last: HOVEMANN

4. DATE OF DEATH: Month: 12 — Day: 13 — Year: 1967

5. SEX: MALE

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 9-20-81

9. AGE (In years lost birthday) 86 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Jeweler Buyer

10b. KIND OF BUSINESS OR INDUSTRY: Jewelry

11. BIRTHPLACE (County & State, or foreign country): Germany

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Herman Hovemann

14. MOTHER'S MAIDEN NAME: Pauline Koerner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give wor or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs. Marian VanHouten — Address: Severna Park, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Hear t Disease — INTERVAL BETWEEN ONSET AND DEATH: 1956
420.1
Conditions, if ony, which gove rise to immediate couse (a), stating the underlying cause last.
DUE TO (b): Generalized arteriosclerosis — 1956
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Previous Coronary Thrombosis 1956

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Yeor Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify thot (I) (this hospitol) attended the deceased from July, 1966, to Dec., 1967, thot (I) (we) last saw the deceased alive on Nov. 19 67, and thot death occurred at 5A M, from couses and on the dote stoted above.

22a. SIGNATURE: Francis I. Codd — ATTENDING PHYS. xxx M.D. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 12-14-67

22c. PHYSICIAN'S NAME (Type): Francis I. Codd M.D.

22d. ADDRESS: Severna Park, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

23b. DATE THEREOF: 12-14-67

23c. NAME OF CEMETERY OR CREMATORY: Fee Crematory

23d. LOCATION (City or Town) (County) (State): Washington D. C.

24. FUNERAL DIRECTOR: Robert S. Barnes — ADDRESS: Severna Park, Md.

25a. REC'D BY REGISTRAR DATE: DEC 18 1967

25b. REGISTRAR'S SIGNATURE: Florence Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar ta burial, cremation, ar removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If [illegible] is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1 [illegible] to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form [illegible]. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

16354

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16346

1. PLACE OF DEATH
a. COUNTY: A. A. Co. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural.
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MD
b. COUNTY: AA Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis — 021
d. STREET ADDRESS: Defense Highway
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Douglas. Middle: Lee Lost: Hunt

4. DATE OF DEATH: Month: 12 Day: 19 Year: 1967

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Nov 17, 1944

9. AGE (In years last birthday): 23 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SURVEYOR

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Annapolis, Md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: HAROLD L. HUNT

14. MOTHER'S MAIDEN NAME: Ruth Duke

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 212-42-6858

17. INFORMANT: Address: Harold L Hunt Annapolis - Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Gunshot wound Chest — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 976X
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Gunshot wound Chest

20c. TIME OF INJURY Month, Day, Year: Hour a.m. p.m. 12/19 1967

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Hospice

20f. (City or town): (County): AA Co. (State): MD

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☑, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: [signature] M.D.
EXAMINER'S NAME (Type): E. Linhart Jr.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county):

22. DATE SIGNED: 12-19-67

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 12/22/67
23c. NAME OF CEMETERY OR CREMATORY: St Mary's
23d. LOCATION (City or Town): Annapolis (County): AA (State): Md

24. FUNERAL DIRECTOR: T A Handerty ADDRESS: Annapolis, Md

25a. REC'D BY REGISTRAR DATE: DEC 29 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

16355 — 17885

1. DECEASED-NAME (Type or print): First: Albert; Middle: ; Last: Jacobs
2a. DATE OF DEATH: Month 12/29 Day Year 67
2b. HOUR: 1:30 PM
3. SEX: Male
4. RACE: White
5. DATE OF BIRTH: 8/9/03
6. AGE (In years last birthday): 64 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN
7a. BIRTHPLACE (State or foreign country): Pennsylvania
7b. CITIZEN OF WHAT COUNTRY?: USA
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
9. COUNTY OF DEATH: Anne Arundel Md.
10. CITY OR TOWN OF DEATH: Crownsville
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Crownsville State Hosp.
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.):
12b. KIND OF BUSINESS OR INDUSTRY:
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland
13b. COUNTY:
13c. CITY OR TOWN: Baltimore
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET AND NUMBER: 1208 E. Baltimore Street
14. FATHER'S NAME First: Charles; Middle: ; Last: K Jacobs
15. MOTHER'S MAIDEN NAME First: Margaret ?; Middle: ; Last:
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): YES (If yes give war or dates of service): USN
16b. SOCIAL SECURITY NO.: 188-20-2558
17. INFORMANT: Hospital Records, Crownsville, Maryland — Address:

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardio vascular accident(right hemiplegia)
443 X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b): arteriosclerotic hypertension with vascular disease.
DUE TO, OR AS A CONSEQUENCE OF (c):
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES ☐ NO ☒
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medicol exominer)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)
21d. INJURY OCCURRED While at work ☐ Not while at work ☐
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. **I certify** thot (I) (this haspital) attended the deceased from 10\01, 19 67 to 12/29, 19 67, that (I) (we) last saw the deceased alive an 12/29 19 67 ond that in (my) (our) opinion death occurred on the dote ond hour and from the couses stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Hildegarde Reissman DEGREE — ATTENDING PHYS. ☐ MED. DIRECTOR ☒ STAFF PHYS. ☐
22c. DATE SIGNED: 12/29/67
22d. PHYSICIAN'S NAME (Type): Hildagarde Reissman, M.D.
22e. ADDRESS: Crownsville State Hospital, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)
23b. DATE
23c. NAME OF CEMETERY OR CREMATORY: Anatomy Board of Md.
23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR — ADDRESS
25a. REC'D BY REGISTRAR DATE: JAN 15 1968
25b. REGISTRAR'S SIGNATURE: Edward Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16356

CERTIFICATE OF DEATH

1634?

1. **PLACE OF DEATH**
   a. COUNTY: Anne Arundel — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Linthicum Heights
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): 407 Medora Road

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Howard
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkridge
   d. STREET ADDRESS: 5502 Main Street
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Bessie — Middle: S. — Last: Janson

4. **DATE OF DEATH**: Month: 12 — Day: 26 — Year: 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 7/12/87

9. AGE (In years last birthday): 80 yrs.
   IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William L. Rigby

14. MOTHER'S MAIDEN NAME: Sallie E. Geddes

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mr. Charles J. Janson, 407 Medora Rd. — Address: Linthicum Hghts. 21090

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): Acute Left Ventricular Failure — INTERVAL BETWEEN ONSET AND DEATH: 2 hours
   443 X
   DUE TO (b): Hyperte ov Arteri Sclerotic Cardiovas Dis — 10 years
   Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
   DUE TO (c):

   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Oct 19, 1958 to 12/26, 19 67 that (I) (we) last saw the deceased alive on Oct 19, 1958, and that death occurred at 9 AM, from causes and on the date stated above.

22a. SIGNATURE: Benjamin Berdann M.D. — ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 12/27/67

22c. PHYSICIAN'S NAME (Type): Dr. Benjamin Berdann

22d. ADDRESS: 615 Hammonds Lane A. A. Co.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 12/29/67

23c. NAME OF CEMETERY OR CREMATORY: Loudon Park Cemetery

23d. LOCATION (City or Town) (County) (State): Baltimore Md.

24. FUNERAL DIRECTOR: Howard H. Hubbard Funeral Home, 4107 Wilkens Ave. — ADDRESS: 21229

25a. REC'D BY REGISTRAR DATE: DEC 28 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Jr

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16357

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16348

1. PLACE OF DEATH
   a. COUNTY: Anne Arundel — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
   c. LENGTH OF STAY IN 1b: Mins.
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Anne Arundel General Hospital D.O.A.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Anne Arundel
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - LOTHIAN
   d. STREET ADDRESS: Route 1 - Box 173
   e. IS RESIDENCE ON A FARM? YES ☐ NO XX

3. NAME OF DECEASED (Type or print): First JAMES — Middle WEBSTER JOHNSON — Last III

4. DATE OF DEATH: Month Dec. — Day 10 — Year 19 67

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ — Infant

8. DATE OF BIRTH: Aug. 22-67

9. AGE (In years last birthday) yrs.: IF UNDER 1 YEAR Months 3 Days 12 — IF UNDER 24 HRS. Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): **********

10b. KIND OF BUSINESS OR INDUSTRY: ******* **

11. BIRTHPLACE (State or foreign country): Calvert Co. Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James W. Johnson Jr.

14. MOTHER'S MAIDEN NAME: Gladys Jenkins

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: ***-****

17. INFORMANT: James W. Johnson Jr. Rt.1-Box173 LOTHIAN, MARYLAND P.O.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: Hours
   DUE TO (b): 493X
   DUE TO (c):
   Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☑, Inquiry ☑, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: E.G. Linhardt M.D.

EXAMINER'S NAME (Type): E.G. LINHARDT

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county)

22. DATE SIGNED: 12-10-67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Dec. 12-67

23c. NAME OF CEMETERY OR CREMATORY: MOSES

23d. LOCATION (City or Town) (County) (State): DRUDY A.A.Co. Maryland

24. FUNERAL DIRECTOR — ADDRESS: C.E.Hicks III Annapolis, Marylahd

25a. REC'D BY REGISTRAR DATE: DEC 14 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

2-040504

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

16358

CERTIFICATE OF DEATH

16349

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Edgewater
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Herbert — Middle: — Last: JONES

4. DATE OF DEATH: Month: December — Day: 30 — Year: 1967

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: January 3, 1915

9. AGE (In years last birthday): 52 yrs.

IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U. S.

13. FATHER'S NAME: Josiah Jones

14. MOTHER'S MAIDEN NAME: Bertha Spriggs

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 218-12-9825

17. INFORMANT Address: Virgie Jones Edgewater Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): massive Cerebral hemorrhage
DUE TO (b): Severe Hypertension
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 1 year

331X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): massive Cerebral hemorrhage right side.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: — a.m. / p.m. — Month, Day, Year: — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):

20f. (City or town) (County) (State)

21. I certify that (I) ~~(this hospital)~~ attended the deceased from ....., 19....., to Dec. 30, 1967, that (I) ~~(we)~~ last saw the deceased alive on ....., 19....., and that death occurred at 7:25 pm, from the causes and on the date stated above.

22a. SIGNATURE: Richard E. Cook M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 1-2-68

22c. PHYSICIAN'S NAME (Type): Richard E. Cook, M.D.

22d. ADDRESS: 20 Dean Street, Annapolis, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 1-4-1968

23c. NAME OF CEMETERY OR CREMATORY: Hope Memorial

23d. LOCATION (City, town or county) (State): Edgewater Md.

24 FUNERAL DIRECTOR'S SIGNATURE: William Reese #

ADDRESS: Annapolis Md

25a. REC'D BY REGISTRAR DATE: JAN 4 1968

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
20M 5-63

Item 18 Film 396 1-8-68 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16359

CERTIFICATE OF DEATH

16350

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FT GEO G. MEADE
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): KIMBROUGH ARMY HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: VIRGINIA
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CHESAPEAKE
d. STREET ADDRESS: ROUTE #3, BOX 189
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: LEON — Middle: E. — Last: JONES

4. DATE OF DEATH: Month: DECEMBER — Day: 9 — Year: 19 67

5. SEX: MALE

6. COLOR OR RACE: NEGRO

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: OCT 24, 1946

9. AGE (In years last birthday): 21 yrs.

IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Soldier

10b. KIND OF BUSINESS OR INDUSTRY: U.S.Army

11. BIRTHPLACE (County & State, or foreign country): Ahoskie, N.C.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Jessie Jones, Jr.

14. MOTHER'S MAIDEN NAME: Annie E. Ruffin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give wor or dotes of service): 23Mar66-9Dec67

16. SOCIAL SECURITY NO.: 230-66-6533

17. INFORMANT Address: Official military records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): BILATERAL PULMONARY MENINGOCOCCEMIA
DUE TO
(b): EDEMA OF ETIOLOGY TO BE DETERMINED
DUE TO
(c):
Conditions, if ony, which gove rise to immediate couse (a), stating the underlying cause lost.
057.1
INTERVAL BETWEEN ONSET AND DEATH: -2-HR-

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased WAS DOA, X, on 9 DEC, 67, that I (saw) (did not see) the deceased alive on ____, and that death occurred at 5:35 P.M. from causes and on the date stated above.

22a. SIGNATURE: Frederick Shuster Cpt MC — M.D. ☐ ATTENDING PHYS. ☐ MED. DIRECTOR ☒ STAFF PHYS.

22b. DATE SIGNED: 9 DEC 67

22c. PHYSICIAN'S NAME (Type): FREDERICK SHUSTER,CPT,MC

22d. ADDRESS: KIMBROUGH ARMY HOSP,FT GEO G MEADE,MD

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 12/14/67

23c. NAME OF CEMETERY OR CREMATORY: Rosewell Cemetery

23d. LOCATION (City or Town) (County) (State): Norfolk, Virginia

24. FUNERAL DIRECTOR: HOWARD COUNTY Funeral Home Harry Witzke — ADDRESS: Ellicot City Maryland

25a. REC'D BY REGISTRAR DATE: DEC 14 1967

25b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16360

CERTIFICATE OF DEATH

16351

1. **PLACE OF DEATH**
   a. COUNTY: A. A. Co. — MARYLAND
   b. CITY OR TOWN (If outside corparate limits, write RURAL and give nearest tawn): RIVIERA BCH.
   c. LENGTH OF STAY IN 1b: 30 mi
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 165 PARK RD. RIVIERA BCH. A.A. Co.

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Md. — b. COUNTY: C
   c. CITY OR TOWN (If outside corparate limits, write RURAL and give nearest tawn): Baltimore
   d. STREET ADDRESS: 1168 Washington Blvd.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. **NAME OF DECEASED** (Type or print): First: WALTER — Middle: F. — Last: KAMM

4. **DATE OF DEATH**: Manth: Dec. — Doy: 31 — Year: 1967

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: 11/28/1893

9. AGE (In years last birthday): 74 yrs.
   IF UNDER 1 YEAR: Months / Doys
   IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Shipping Dept.

10b. KIND OF BUSINESS OR INDUSTRY: U.S. Steel

11. BIRTHPLACE (County & State, or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: John Kamm

14. MOTHER'S MAIDEN NAME: Johanna ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes. (If yes give war or dates of service): W.W.I

16. SOCIAL SECURITY NO.: ✓

17. **INFORMANT**: Louise Wandasewicz — Address: 165 Park Rd. A.A. Co.

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Sudden
   DUE TO
   Conditians, if any, which gave rise ta immediate cause (a), stating the underlying cause lost.
   (b): Arteriosclerotic cardiovascular disease — DUE TO — INTERVAL BETWEEN ONSET AND DEATH: Several years
   (c):

   4201

   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or tawn) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Feb. , 1965 , ta Dec. 31 , 1967 , that (I) (we) last saw the deceased alive an Dec 31 1967 , and that death accurred at 11:30 M, from causes ond on the date stated above.

22a. SIGNATURE: S J. Liu — M.D. ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: Jan. 8 1968

22c. PHYSICIAN'S NAME (Type): S. J. Liu

22d. ADDRESS: 5301 Harford Rd. Balto. Md. 21214

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 1/4/67

23c. NAME OF CEMETERY OR CREMATORY: Baltimore National Cem.

23d. LOCATION (City or Town) (County) (State): Baltimore, Md.

24. FUNERAL DIRECTOR: John J. Cowan Son, Inc. — ADDRESS: 901 Hollins St. Balto. Md.

25a. REC'D BY REGISTRAR DATE: JAN 4 1968

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form DM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16361

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16353

1. PLACE OF DEATH
a. COUNTY: A.A. Co
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): PASADENA
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): D.O.A-NORTH. ARUNDEL.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MD
b. COUNTY: AA Co
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pasadena - 02-1
d. STREET ADDRESS: Rt 11 - Box 61
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: PAUL Middle: Leroy Last: Kelly

4. DATE OF DEATH: Month: 12 Day: 7 Year: 1967

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 05 1-12-XXX

9. AGE (In years last birthday): 62 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sign Artist

10b. KIND OF BUSINESS OR INDUSTRY: Self Employed

11. BIRTHPLACE (State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: George W. Kelley

14. MOTHER'S MAIDEN NAME: Reath Mays

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Agnes C. Kelley Address: Rt.11 Box 61 Pasadena 21122

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerosis generalized
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4500
INTERVAL BETWEEN ONSET AND DEATH: Years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m., p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: [signature] M.D.

EXAMINER'S NAME (Type): E. Lenhardt.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county):

22. DATE SIGNED: 12-7-67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 12/11/67

23c. NAME OF CEMETERY OR CREMATORY: Glen Haven Memorial Park

23d. LOCATION (City or Town) (County) (State): Glen Burnie Anne Arundel Co.

24. FUNERAL DIRECTOR: McCully Funeral Home ADDRESS: 237 Patapsco Ave. 21225

25a. REC'D BY REGISTRAR DATE: DEC 11 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16362

CERTIFICATE OF DEATH

16354

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore Suburban
c. LENGTH OF STAY IN 1b: 18 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 906 Victory Ave.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore Suburban
d. STREET ADDRESS: 906 Victory Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Ella — Middle E. — Last Lanham
4. DATE OF DEATH: Month Dec. — Day 10, — Year 19 67

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 26, 1888
9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (County & State, or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: William J. Ford
14. MOTHER'S MAIDEN NAME: Ella Grant

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.: None
17. INFORMANT — Address: Mr. John Sedlmayer 4713 Meist Drive (21206

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hypertensive cardio-vascular disease — INTERVAL BETWEEN ONSET AND DEATH
4200
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Generalized arterio-sclerotic heart disease
DUE TO
(c) Senile dementia

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour o.m. p.m. — 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June 19 46, to Dec 10, 19 67, that (I) (we) last saw the deceased alive on 12:0 19 67, and that death occurred at 5A M, from causes and on the date stated above.

22a. SIGNATURE: Samuel Rubin M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Dec. 11, 1967
22c. PHYSICIAN'S NAME (Type): Samuel Rubin
22d. ADDRESS: 201 E. Patapsco Ave. (21225)

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Dec. 13, 1967
23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery
23d. LOCATION (City or Town) (County) (State): Ritchie Hwy, A. A. Co., Md.

24. FUNERAL DIRECTOR — ADDRESS: George J. Gonce 4001 Ritchie Hwy (21225)
25a. REC'D BY REGISTRAR — DATE: DEC 13 1967
25b. REGISTRAR'S SIGNATURE: Charles Snyder

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16363

CERTIFICATE OF DEATH

16355

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physicion and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removol, and in any event, within 72 hours of the death.

VR A15 (4) 25M 1/67

1. **PLACE OF DEATH**
   a. COUNTY: Anne Arundel — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give neorest town): Glen Burnie
   c. LENGTH OF STAY IN 1b: D.O.A.
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): North Arundel Hospital

2. **USUAL RESIDENCE** (Where deceosed lived, if institution: Residence before odmission)
   a. STATE: Maryland — b. COUNTY: Anne Arundel
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest tawn): Severna Park
   d. STREET ADDRESS: 594 Manor Road
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Herbert — Middle: H. — Last: Lappe

4. **DATE OF DEATH**: Month: 12 — Day: 31 — Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 11-8-98

9. AGE (In years last birthday): 69 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mill Right

10b. KIND OF BUSINESS OR INDUSTRY: Ammon Co

11. BIRTHPLACE (County & State, or foreign country): Balto Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Henry Lappe

14. MOTHER'S MAIDEN NAME: Elizabeth Gillelan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 215091169

17. INFORMANT: Hazel Lappe — Address: Above

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): Left Ventricular failure — INTERVAL BETWEEN ONSET AND DEATH: hours
   DUE TO (b): Acute myocardial Infarction — hours
   DUE TO (c):
   Conditions, if any, which gave rise to immediate cause (a), stating the underlying couse last. 4201

   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Nov, 1967 to Dec 31, 1967, that (I) (we) last saw the deceased alive on Dec 31 1967, and that death occurred at 4:10 A M, from couses ond an the dote stoted above.

22a. SIGNATURE: Max C Frank — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 12/31/67

22c. PHYSICIAN'S NAME (Type): MAX C FRANK MD

22d. ADDRESS: 425 SE Ritchie Hwy Glen Burnie MD 21061

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 1-3-68

23c. NAME OF CEMETERY OR CREMATORY: Meadowridge

23d. LOCATION (City or Town) (County) (State): Davsey Md

24. FUNERAL DIRECTOR: Robert S. Barranco — ADDRESS: Severna Park, Md.

25a. REC'D BY REGISTRAR DATE: JAN 4 1968

25b. REGISTRAR'S SIGNATURE: Charles Judge

4 1

16364

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

16356

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): (Dead on arrival) Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL - Edgewater 02.1
d. STREET ADDRESS: Rt-3, Box 98K
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Magdeline; Middle: ; Last: LENTZ

4. DATE OF DEATH: Month: December; Day: 13; Year: 19 67

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Oct. 15, 1898

9. AGE (In years last birthday): 69 yrs.

IF UNDER 1 YEAR: Months: ; Days: — IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Washington, D.C.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: William Mahorney

14. MOTHER'S MAIDEN NAME: Clara (Unknown)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Curtis Dye; Rt. 2, Box 82; Edgewater, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(b): Arteriosclerosis — unknown
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4200

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from April, 1963 to August 17 1967 that (I) (~~we~~) last saw the deceased alive on June 17 1967, and that death occurred at 8:00 AM, from causes and on the date stated above.

22a. SIGNATURE: Wm. P. Stephens M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 12-13-67

22c. PHYSICIAN'S NAME (Type): William P. Stephens, MD.

22d. ADDRESS: 38 Cornhill St., Annapolis, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Dec. 15, 1967

23c. NAME OF CEMETERY OR CREMATORY: Beulah Baptist Cem.

23d. LOCATION (City or Town) (County) (State): Fairfax Co., Va.

24. FUNERAL DIRECTOR: Ives Funeral Home ADDRESS: 2847 Wilson Blvd. Arlington, Virginia

25a. REC'D BY REGISTRAR DATE DEC 19 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16365

CERTIFICATE OF DEATH

16357

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 123 Cathedral St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Joseph — Middle: (none) — Last: LEVY

4. DATE OF DEATH: Month: December — Day: 15 — Year: 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Oct. 5, 1886
9. AGE (In years last birthday): 81 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): proprietor
10b. KIND OF BUSINESS OR INDUSTRY: retail dress
11. BIRTHPLACE (County & State, or foreign country): Baltimore City, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: David Levy
14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): no
16. SOCIAL SECURITY NO.: 215-16-5735
17. INFORMANT: Rose Goldberg Levy - same as #2 above — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Prolonged Ileus — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b): Perforated Duodenal Ulcer
DUE TO (c):
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
5411

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Doy, Yeor Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~the physician~~) attended the deceased from _____, 19____, to Dec. 15, 1967, that (I) (~~he~~) last saw the deceased alive on Dec. 15 1967, and that death occurred at 9:38 AM, from couses ond on the date stated abave.

22a. SIGNATURE: Stephen B. Hiltabidle — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Dec 15 67
22c. PHYSICIAN'S NAME (Type): Stephen B. Hiltabidle, M.D.
22d. ADDRESS: 121 Cathedral St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12/17/67
23c. NAME OF CEMETERY OR CREMATORY: Kneseth Israel Cemetery
23d. LOCATION (City or Town) (County) (State): Annapolis A.A. Md.

24. FUNERAL DIRECTOR: Beverley E. Hopping — ADDRESS: Beverley E. Hopping
HOPPING FUNERAL HOME - Annapolis, Md.

25a. REC'D BY REGISTRAR DATE: DEC 18 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16366 16358

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First / Middle / Last	Margaret Mary Lewis (Mary M.)	2a. DATE OF DEATH Month Day Year	December 31, 1967
2b. HOUR	M		
3. SEX	Female	4. RACE	White
5. DATE OF BIRTH	Jan. 18, 1911	6. AGE (In years last birthday)	56 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS		IF UNDER 24 HRS.: HOURS / MIN	
7a. BIRTHPLACE (State or foreign country)	Nebraska	7b. CITIZEN OF WHAT COUNTRY?	U.S.
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]		9. COUNTY OF DEATH	Anne Arundel Co., Md.
10. CITY OR TOWN OF DEATH	Glen Burnie	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	N. Arundel Convalescent Center
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	Housewife	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	Maryland	13b. COUNTY	Anne Arundel
13c. CITY OR TOWN	Pasadena	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	
13e. STREET AND NUMBER	Rt. 1, Box 41 (Pinehurst)		
14. FATHER'S NAME First / Middle / Last	John A. McNelis	15. MOTHER'S MAIDEN NAME First / Middle / Last	Mary ---
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown	No	16b. SOCIAL SECURITY NO. (If yes give war or dates of service)	526-32-0699
17. INFORMANT Address	Kennett Lewis, (same)		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CEREBRAL EDEMA — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 wks

1939

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Astrocytoma — 2 YRS

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medicol exominer)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port I or Port 2, Item 18.)	
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. I certify that (I) (~~this hospital~~) attended the deceased from 12 , 1966, to 12-31, 1967, that (I) (~~saw~~) last saw the deceased alive on 12-4 1967, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~was~~) (~~did~~) (did not) view the body after death.

22b. SIGNATURE	C. Earl Hill	DEGREE	ATTENDING PHYS. [X]	MED. DIRECTOR [ ]	STAFF PHYS. [ ]
22c. DATE SIGNED	Jan. 2, 1967				
22d. PHYSICIAN'S NAME (Type)	C. Earl Hill, M.D.	22e. ADDRESS	395 Ft. Smallwood Rd. Pasadena, Md.		

23a. BURIAL, CREMATION, REMOVAL (Specify)	Burial	23b. DATE	Jan. 3,1968	23c. NAME OF CEMETERY OR CREMATORY: Glen Haven Memorial Pk.
23d. LOCATION (City or Town) (County) (State)	Ritchie Hgwy., A.A.Co., Md.			
24. FUNERAL DIRECTOR ADDRESS	George J. Gonce-4001 Ritchie Hgwy., Baltimore	25a. REC'D BY REGISTRAR DATE	JAN 4 1968	25b. REGISTRAR'S SIGNATURE: Juliana Judge

VR A15 (M) 30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16367

CERTIFICATE OF DEATH

16359

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporote limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corparate limits, write RURAL and give nearest tawn): Annapolis
d. STREET ADDRESS: 23 Acorn Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Joyce — Middle: G. — Lost: Loveless
4. DATE OF DEATH: Month: Dec — Day: 23 — Year: 1967
5. SEX: female
6. COLOR OR RACE: caus.
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 24 Sept. 1918
9. AGE (In years lost birthday): 49 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): secretary
10b. KIND OF BUSINESS OR INDUSTRY: wholesale auto parts
11. BIRTHPLACE (County & Stote, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Joseph Stubbins
14. MOTHER'S MAIDEN NAME: Marian Summers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give wor or dotes of service):
16. SOCIAL SECURITY NO.: 579-18-5735
17. INFORMANT: Walter E. Loveless - same as #2 above — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CARCINOMA — INTERVAL BETWEEN ONSET AND DEATH: 2 WEEKS
DUE TO (b): OBSTRUCTION, SMALL BOWEL — 4 WEEKS
DUE TO (c): EXTENSIVE SQUAMOUS CELL CARCINOMA OF [illegible] WITH METS TO [illegible] — 5 YRS AND 6 MONTHS
Conditions, if ony, which gave rise to immediote couse (a), stoting the underlying couse lost.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). WITH MARKED EXTENSION AND METASTASIS
DEHYDRATION
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (~~this hospital~~) attended the deceased from MARCH, 1967, to DEC 23, 1967, that (I) (—) last saw the deceased alive an Dec. 22 1967, and that death accurred at 10:37 A M, fram causes and an the date stated abave.

22a. SIGNATURE: Robert A. Riley Jr — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/23/67
22c. PHYSICIAN'S NAME (Type): ROBERT A. RILEY JR
22d. ADDRESS: 95 CATHEDRAL ST, ANNAPOLIS, MD

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Dec. 27, 1967
23c. NAME OF CEMETERY OR CREMATORY: Hillcrest Memorial Cem.
23d. LOCATION (City or Town) (County) (State): Annapolis A.A. Md.

24. FUNERAL DIRECTOR ADDRESS: Beverley E. Hopping — Beverley E. Hopping
HOPPING FUNERAL HOME - Annapolis, Md.

25a. REC'D BY REGISTRAR DATE: DEC 27 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16368

CERTIFICATE OF DEATH

16369

1. PLACE OF DEATH
a. COUNTY: AA — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): North Anndel Emergency Hosp

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md
b. COUNTY: AA
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie 02.1
d. STREET ADDRESS: 511 Second Avenue SW
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Thomas Middle (nmi) Last Mahon (Mahon)

4. DATE OF DEATH: Month 12 Day 13 Year 1967

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 5/22/1877
9. AGE (In years last birthday): 90 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cab Driver (ret.)
10b. KIND OF BUSINESS OR INDUSTRY: Self-Employed
11. BIRTHPLACE (County & State, or foreign country): Ireland
12. CITIZEN OF WHAT COUNTRY? U-S-A.

13. FATHER'S NAME: Michael Mahon
14. MOTHER'S MAIDEN NAME: Mary Mahon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 079-28-9444A
17. INFORMANT: Mrs. Helen Mahon (wife) Address: Hospital chart Same As #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Myocardial infarction
DUE TO (b): ASHD
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4201
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Urinary infection Senility dehydration
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour o.m. p.m., 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 12/11/67, 19__ to 12/13/67 19__, that (I) (we) last saw the deceased alive on 12/12/67 19__, and that death occurred at 3:30 P.M., from causes and on the date stated above.

22a. SIGNATURE: J.B. Ramirez M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/13/67
22c. PHYSICIAN'S NAME (Type): J.B. RAMIREZ
22d. ADDRESS: 3527 Annapolis Rd Balto 27 325 Hospital Drive Glen Burnie

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Dec. 16, 1967
23c. NAME OF CEMETERY OR CREMATORY: Calvary Cemetery
23d. LOCATION (City or Town) (County) (State): Queens, New York, New York

24. FUNERAL DIRECTOR: R. V. Singleton ADDRESS: Singleton Funeral Home Glen Burnie, Maryland
25a. REC'D BY REGISTRAR DATE: DEC 18 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16369

CERTIFICATE OF DEATH

16361

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. **PLACE OF DEATH**
   a. COUNTY: Anne Arundel — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
   c. LENGTH OF STAY IN 1b: DOA Hours
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): North Arundel Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Anne Arundel
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
   d. STREET ADDRESS: RFD, Box 263
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Don — Middle: Richard — Last: Marshall

4. **DATE OF DEATH**: Month: December — Day: 17 — Year: 1967

5. SEX: Male

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 7-30-10

9. AGE (In years last birthday): 57 yrs.
   IF UNDER 1 YEAR: Months / Days
   IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Truck Driver

10b. KIND OF BUSINESS OR INDUSTRY: Maryland Transfer

11. BIRTHPLACE (County & State, or foreign country): North Carolina

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Cleve Marshall

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
   (If yes give wor or dotes of service)

16. SOCIAL SECURITY NO.: 237-24-8682

17. INFORMANT — Address: Mrs. Viola C. Marshall, same as 2

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): Cerebral hemorrhage
   DUE TO (b): Hypertensive Cardiovascular disease
   DUE TO (c):
   Conditions, if any, which gove rise to immediate cause (a), stating the underlying couse last.
   443 X
   INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Yeor Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** thot (I) (~~this hospital~~) attended the deceased from 11/18/67, 1967, to 11/18/67, 1967, that (I) (~~we~~) last saw the deceased alive an 11/18/67 1967, and that death occurred at 11:40 AM, from causes and an the date stated abave

22a. SIGNATURE: Edmond I. Moushabek M.D. — ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 12/17/67

22c. PHYSICIAN'S NAME (Type): Edmond I. Moushabek

22d. ADDRESS: 510 Marley Station Rd, G.B.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 20 Dec. 67

23c. NAME OF CEMETERY OR CREMATORY: Glen Haven Memorial Park

23d. LOCATION (City or Town) (County) (State): Glen Burnie, Md.

24. FUNERAL DIRECTOR — ADDRESS: Kirkley Funeral Homes, Glen Burnie, Md.

25a. RECD BY REGISTRAR DATE: DEC 20 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16370 Item 17 Film G396 1/3/68 kk 16362

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physicion and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 25M 1/67

PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 168 Green Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Lost	4. DATE OF DEATH Month	Day	Year
Katie	Bell	MARSHALL	December	24	19 67

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White		November 18, 1890	77 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOME	HOUSEWIFE	ANNAPOLIS Maryland	U. S.

13. FATHER'S NAME: EVERETT HUBBARD
14. MOTHER'S MAIDEN NAME: MARGARET THOMPSON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give wor or dotes of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
—	—		MRS. RALPH THOMPSON Hubbard	#2

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	PULMONARY EDEMA	6 HOURS
DUE TO (b)	CORONARY THROMBOSIS	2 DAYS.
DUE TO (c)	ARTERIOSCLEROTIC HEART DISEASE	10 YEARS

4201

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): DIABETES MELITUS, UREMIA

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)			
20c. TIME OF INJURY Manth, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Hame, farm, factory, street, office bldg., etc.)	20f. (City or tawn)	(County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from JAN 2, 1961, to 24 DEC, 1967, that (I) (we) last saw the deceased alive on 24 DEC 1967, and that death occurred at 12:57 P. M. from causes and on the date stated above.

22a. SIGNATURE: Edward S. Beck M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 12/26/67
22c. PHYSICIAN'S NAME (Type): EDWARD S. BECK. — 22d. ADDRESS: FRANKLIN St. ANNAPOLIS, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	12-28-67	ST. ANNE'S	ANNAPOLIS A.A. MD.

24. FUNERAL DIRECTOR — ADDRESS: John M. Taylor Sons Annapolis, Md.
25a. RECD BY REGISTRAR DATE: DEC 27 1967 — 25b. REGISTRAR'S SIGNATURE: [illegible]

16371

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16363

1. DECEASED-NAME (Type or print): First James Middle H Last MASON
2a. DATE OF DEATH: Month 12 Day 25 Year 67
2b. HOUR: M
3. SEX: Male
4. RACE: Colored
5. DATE OF BIRTH: 1/27/1897
6. AGE (In years last birthday): 70 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN
7a. BIRTHPLACE (State or Foreign Country): Maryland
7b. CITIZEN OF WHAT COUNTRY? U.S.A.
8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. COUNTY OF DEATH: Anne Arundel Md.
10. CITY OR TOWN OF DEATH: Annapolis
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): U.S. General Hosp.
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Retired
12b. KIND OF BUSINESS OR INDUSTRY: Govt. Adm.
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
13b. COUNTY: Anne Arundel Co. Md.
13c. CITY OR TOWN
13d. INSIDE CITY LIMITS? YES ☑ NO ☐
13e. STREET AND NUMBER: 14 Johnson St.
14. FATHER'S NAME First Mansfield Middle Mason Last
15. MOTHER'S MAIDEN NAME First Emma Middle Nelson Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown: No (If yes give war or dates of service)
16b. SOCIAL SECURITY NO.
17. INFORMANT: Marie Mason Address: Annapolis Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Embolism
DUE TO, OR AS A CONSEQUENCE OF (b): Cerebral Arterio Sclerosis Hypertensive Cardiovas
DUE TO, OR AS A CONSEQUENCE OF (c): Renal Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 443X
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 6 Yrs 1 Month 1 Day 1967
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☐
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work ☐ Not while at work ☐
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from Dec 1st, 1967, to Dec 25, 1967, that (I) (we) last saw the deceased alive on Dec 25, 1967, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: R. Richardson M.D. DEGREE ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
22c. DATE SIGNED: 12/27/67
22d. PHYSICIAN'S NAME (Type): R. RICHARDSON MD
22e. ADDRESS: 110 Church St Annapolis

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 12/29/67
23c. NAME OF CEMETERY OR CREMATORY: John Wesley
23d. LOCATION (City or Town) (County) (State): Waterbury Q.A. Md.
24. FUNERAL DIRECTOR: William Reese ADDRESS: Annapolis Md.
25a. REC'D BY REGISTRAR DATE: JAN 2 1968
25b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physicion and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16372

CERTIFICATE OF DEATH

16364

1. PLACE OF DEATH
a. COUNTY Anne Arundel Cty. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) P.O. Box 44 Mayo, Md.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY A. A
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mayo, 02-1
d. STREET ADDRESS P. O. Box 44
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First: HARRY Middle: VERNON Last: Maulding
4. DATE OF DEATH Month: Dec. Day: 18 Year: 1967
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 6-10-93
9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Gov. Worker-Engineer
10b. KIND OF BUSINESS OR INDUSTRY: Dept. of Int.
11. BIRTHPLACE (County & State, or foreign country): VIRGINIA
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: JAMES E MAULDING
14. MOTHER'S MAIDEN NAME: THERESA C. FANNON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service)
16. SOCIAL SECURITY NO. 212-36-0698
17. INFORMANT: Mrs. Theresa C. Warring Address 9600 Dilston S.S., Md. Dr

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) (Probable) Cardiac arrest — INTERVAL BETWEEN ONSET AND DEATH: minutes.
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Coronary artery insufficiency — 10 yrs.
DUE TO
(c) Generalized arteriosclerosis — 15 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Sept. 1965, to Dec. 1967, that (I) (we) last saw the deceased alive on Dec. 21 1967, and that death occurred at 1:15 P.M. from causes and on the date stated above.

22a. SIGNATURE John L Hedeman — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED 12/18/67
22c. PHYSICIAN'S NAME (Type) John L. Hedeman
22d. ADDRESS Annapolis, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify) burial
23b. DATE THEREOF 12/21/67
23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery
23d. LOCATION (City or Town) (County) (State) Washington, D. C.

24. FUNERAL DIRECTOR The S.H. Hines Co. ADDRESS 2901 14th St. N. W.
25a. REC'D BY REGISTRAR DATE DEC 26 1967
25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16373

CERTIFICATE OF DEATH

16365

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FT GEO G MEADE, MARYLAND
c. LENGTH OF STAY IN 1b: 17 Days

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ANNE ARUNDEL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): GLEN BURNIE
02.1
d. STREET ADDRESS: 426 ARBOR DRIVE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): KIMBROUGH ARMY HOSPITAL

3. NAME OF DECEASED (Type or print): First JOHN Middle THOMAS Lost MC COY

4. DATE OF DEATH: Month DECEMBER Doy 11 Year 19 67

5. SEX: MALE

6. COLOR OR RACE: CAU

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 9/15/1929

9. AGE (In years last birthday): 38 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RET USA

10b. KIND OF BUSINESS OR INDUSTRY: SOLDIER

11. BIRTHPLACE (County & Stote, or foreign country): WEBSTER, NY.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: WILLIAM HENRY MC COY

14. MOTHER'S MAIDEN NAME: JANET E. BROWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes give war or dates of service) 1948-Apr 66

16. SOCIAL SECURITY NO.: 081-32-8110

17. INFORMANT: BEVERLY MC COY(W) Same as # 2 — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): SHOCK, PULMONARY EDEMA, CONGESTIVE HEART
DUE TO: FAILURE
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
(b):
DUE TO:
(c):
4341
INTERVAL BETWEEN ONSET AND DEATH: Approx 1yr

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (X) (this hospital) attended the deceased from 24 Nov, 1967, to 11 Dec, 1967, that (X) (we) last saw the deceased alive an 11 Dec 67 19___, and that death occurred at 3:30 A.M., from causes and on the date stated above.

22a. SIGNATURE: Lynn W. Holder, MC M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 11 Dec 67

22c. PHYSICIAN'S NAME (Type): LYNN W. HOLDER, CPT, MC

22d. ADDRESS: KIMBROUGH ARMY HOSPITAL, FT GEO G MEADE MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 12/14/67

23c. NAME OF CEMETERY OR CREMATORY: Arlington Natioanl

23d. LOCATION (City or Town) (County) (State): Arlington, Virginia

24. FUNERAL DIRECTOR: Raymond C. Fink
ADDRESS: Glen Burnie, Md.

25a. REC'D BY REGISTRAR DATE: DEC 14 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16374

CERTIFICATE OF DEATH

16366

1. PLACE OF DEATH
a. COUNTY: A-A. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 10 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): A-A. Co. Gen. Hosp.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md. — b. COUNTY: A. A. Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Severna Park
d. STREET ADDRESS: 27 Sunset Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: NELLIE — Middle: Mae — Last: McCulloch

4. DATE OF DEATH: Month: 12 — Day: 22 — Year: 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 1-30-94
9. AGE (In years last birthday): 73 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Saleslady
10b. KIND OF BUSINESS OR INDUSTRY: Dept Store
11. BIRTHPLACE (County & State, or foreign country): New York
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles Malpas
14. MOTHER'S MAIDEN NAME: Louise Monsachen

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 038039927
17. INFORMANT: (A) Mrs. Donald Voss — Address: Above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Chronic glomerulonephritis — INTERVAL BETWEEN ONSET AND DEATH: Unknown
592X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from 4-31- , 19 63 to 12/22 , 1967, that (I) (~~we~~) last saw the deceased alive on 12/22 1967, and that death occurred at 1:35A M, from causes and on the date stated above.

22a. SIGNATURE: Richard I. Hochman — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/22/67
22c. PHYSICIAN'S NAME (Type): Richard I. Hochman, M.D.
22d. ADDRESS: 16 Murray Avenue, Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremated
23b. DATE THEREOF: 12-24-67
23c. NAME OF CEMETERY OR CREMATORY: Lee Crematory
23d. LOCATION (City or Town) (County) (State): Washington D.C.

24. FUNERAL DIRECTOR: Robert S. Sowers — ADDRESS: Severna Park, Md.
25a. REC'D BY REGISTRAR DATE: DEC 26 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Jones

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16375

CERTIFICATE OF DEATH

16367

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Millersville
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Knollwood Manor Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Fannie — Middle: B. — Last: McQuay

4. DATE OF DEATH: Month: Dec. — Day: 19 — Year: 19 67

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 6/23/1879

9. AGE (In years last birthday): 88 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: ----

11. BIRTHPLACE (County & State, or foreign country): Talbot County, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William T. Morris

14. MOTHER'S MAIDEN NAME: Anna Jester

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): ---

16. SOCIAL SECURITY NO.: ---

17. INFORMANT: Mrs. Maysie Cayer, Address: 414 Maple Ave., Glen Burnie, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b): Congestive Heart failure — 2 days
DUE TO (c): Arteriosclerotic Cardiovascular disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4221

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 9,7, 19 66, to 12/19, 19 67, that (I) (we) last saw the deceased alive on 12/12 19 67, and that death occurred at AM, from causes and on the date stated above.

22a. SIGNATURE: Ray M. Smith — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 12/19/67

22c. PHYSICIAN'S NAME (Type): Ray M. Smith, M. D.

22d. ADDRESS: Hahn Professional Bldg., Severna Pk., Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: December 21, 1967

23c. NAME OF CEMETERY OR CREMATORY: Bozman, Cemetery

23d. LOCATION (City or Town) (County) (State): Bozman, Maryland

24. FUNERAL DIRECTOR: Harrison & Leonard — ADDRESS: St. Michaels, Md.

25a. REC'D BY REGISTRAR DATE: DEC 27 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16376

CERTIFICATE OF DEATH

16369

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. **PLACE OF DEATH**
   a. COUNTY: ANNE ARUNDEL — MARYLAND
   b. CITY OR TOWN (If outside corparate limits, write RURAL and give nearest town): RURAL-GLEN BURNIE
   c. LENGTH OF STAY IN 1b: 22 DAYS
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): NORTH ARUNDEL [redacted]-HOSPITAL

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: MARYLAND
   b. COUNTY: ANNE ARUNDEL
   c. CITY OR TOWN (If outside corparate limits, write RURAL and give nearest town): RURAL- ODENTON 021
   d. STREET ADDRESS: APT 1245C SCOTT MANOR
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First HERSCHEL — Middle D. — Lost MEEK

4. **DATE OF DEATH**: Month DECEMBER — Day 14 — Year 1967

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: MARCH 28, 1899

9. AGE (In years last birthday): 68 yrs.
   IF UNDER 1 YEAR: Months — Days
   IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ESTIMATOR

10b. KIND OF BUSINESS OR INDUSTRY: LUMBER COMPANY

11. BIRTHPLACE (County & State, or foreign country): ILLINOIS

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Gary D Meek

14. MOTHER'S MAIDEN NAME: Gladdeal Shearer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service): None

16. SOCIAL SECURITY NO.: 451-03-7982

17. **INFORMANT**: Marguerite Meek Wife — Address: Same as #a

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): Acute Myocardial
   DUE TO (b): Infarction - Anteroseptal
   DUE TO (c): & Thrombus
   Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4201

   INTERVAL BETWEEN ONSET AND DEATH

   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 11/22, 1967, to 12/14, 1967, that (I) (~~was~~) last saw the deceased alive on 12/13, 1967, and that death occurred at 11:45 AM, from causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. ☐ ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 12/15/67

22c. PHYSICIAN'S NAME (Type): Febus Grunberg, M.D.

22d. ADDRESS: 1113 Old Odenton Rd, Odenton

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Dec 18, 1967

23c. NAME OF CEMETERY OR CREMATORY: I.O.F. Cemetery

23d. LOCATION (City or Town) (County) (State): Frederick Town Md.

24. FUNERAL DIRECTOR: E.B. Fleming Singletons Funeral Home — ADDRESS: Crain Hwy, Glen Burnie

25a. REC'D BY REGISTRAR — DATE: DEC 19 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Justice

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16377 Item 23b Film G395 12/11/67 KK

CERTIFICATE OF DEATH

16368

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Annapolis Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Edgewater
d. STREET ADDRESS: Rt 2 Box 220
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: MARGARET Middle: MEREDITH Last:

4. DATE OF DEATH: Month: 12 Day: 4 Year: 19 67

5. SEX: female

6. COLOR OR RACE: caus.

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Mar. 30, 1879

9. AGE (In years last birthday): 88 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired clerk

10b. KIND OF BUSINESS OR INDUSTRY: US Gov't

11. BIRTHPLACE (County & State, or foreign country): unknown

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William M. Meredith

14. MOTHER'S MAIDEN NAME: Terressa A. Richey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service):

16. SOCIAL SECURITY NO.: unknown

17. INFORMANT Address: Mrs. Margaret Arrington - same as #2 above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Generalized arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: Unknown
4500
DUE TO
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
(b):
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 6/3, 1967 to 12/4, 1967, that (I) (we) last saw the deceased alive on 11/9 1967, and that death occurred at 2:45 P.M., from causes and on the date stated above.

22a. SIGNATURE: Richard I. Hochman — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 12/4/67

22c. PHYSICIAN'S NAME (Type): Richard I. Hochman, M.D.

22d. ADDRESS: 16 Murray Avenue, Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal-Burial

23b. DATE THEREOF: 12/6/67

23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery

23d. LOCATION (City or Town) (County) (State): Suitland Prince George Md.

24. FUNERAL DIRECTOR: Emily E. Hopping

ADDRESS: HOPPING FUNERAL HOME - Annapolis, Md.

25a. REC'D BY REGISTRAR DATE: DEC 5 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1

16378

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

16370

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Edgewater
d. STREET ADDRESS: 21 Wilelinor Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Julia — Middle: Teresa — Last: MOGGACH
4. DATE OF DEATH: Month: December — Day: 8 — Year: 19 67
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: October 12, 1881
9. AGE (In years last birthday): 86 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOME
10b. KIND OF BUSINESS OR INDUSTRY: HOUSEWIFE
11. BIRTHPLACE (County & State, or foreign country): Ireland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: JAMES GARVEY
14. MOTHER'S MAIDEN NAME: MARY GARVEY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: GEORGE MOGGACH — Address: #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Septicemia — INTERVAL BETWEEN ONSET AND DEATH: Days?
DUE TO (b): Urinary tract infection — Days
DUE TO (c): Cerebral thrombosis — Months
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
332X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1/1, 1964, to 12/8, 1967, that (I) (we) last saw the deceased alive on 12/8 1967, and that death occurred at 11:40 P.M. from causes and on the date stated above.

22a. SIGNATURE: Gerard Rhine M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/9/67
22c. PHYSICIAN'S NAME (Type): GERARD CHALPIN
22d. ADDRESS: 121 CATHEDRAL ST ANNAPOLIS MD

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 12-11-67
23c. NAME OF CEMETERY OR CREMATORY: ST. MARYS
23d. LOCATION (City or Town) (County) (State): ANNAPOLIS A.A. MD.

24. FUNERAL DIRECTOR: John M. Taylor & Sons — ADDRESS: Annapolis, Md.
25a. REC'D BY REGISTRAR DATE: DEC 12 1967
25b. REGISTRAR'S SIGNATURE: [illegible]

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

16379 Item 7 Film G397 1/24/68 kk 16371

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FORT GEO G MEADE, MD.
c. LENGTH OF STAY IN 1b: 1 DAY
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): KIMBROUGH ARMY HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institutian: Residence before admission)
a. STATE: ALABAMA — b. COUNTY:
c. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest tawn): PLEASANT GROVE
d. STREET ADDRESS: 233 14th STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: DON — Middle: A — Last: MOODY

4. DATE OF DEATH: Month: DECEMBER — Day: 22 — Year: 19 67

5. SEX: MALE

6. COLOR OR RACE: CAU.

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☒

8. DATE OF BIRTH: 18 SEP 23

9. AGE (In years lost birthday): 44 yrs.

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SOLDIER

10b. KIND OF BUSINESS OR INDUSTRY: U.S. ARMY

11. BIRTHPLACE (County & State, or foreign country): RUSSELLVILLE, ALABAMA

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: JAMES R. MOODY

14. MOTHER'S MAIDEN NAME: NANCY B. (MAIDEN NAME UNKNOWN)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na, ar unknawn) (If yes give wor ar dates of service): YES 8 NOV54/22DEC67

16. SOCIAL SECURITY NO.: 416-68 6903

17. INFORMANT Address: UNIT PERSONNEL RECORDS 42d GP, FT GEO G M, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter anly ane cause per line far (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
330X
IMMEDIATE CAUSE (a): SUBARACHNOID HEMORRHAGE IN (R) PARIETAL
DUE TO
(b): AREA ORGANIZING
DUE TO
(c):
Conditions, if ony, which gove rise ta immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: UNKNOWN

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature af injury in Part I or Part II af item 18.)

20c. TIME OF INJURY Manth, Doy, Year Haur o.m. p.m. 19

20d. INJURY OCCURRED While at wark ☐ Nat While at wark ☐

20e. PLACE OF INJURY (Hame, farm, factary, street, affice bldg., etc.)

20f. (City ar tawn) (County) (State)

21. I certify that ☒ (this haspital) attended the deceased from 21 DEC, 1967, to 22 DEC, 1967, that ☐ (we) last saw the deceased alive an 22 DEC 1967, and that death accurred at 6:33 A.M., from causes and on the date stated above.

22a. SIGNATURE: Richard P Behrendt — M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 22 DEC 67

22c. PHYSICIAN'S NAME (Type): RICHARD P. BEHRENDT

22d. ADDRESS: KIMBROUGH ARMY HOSP, FT GEO G MEADE, MD.

23a. BURIAL, ~~CREMATION~~, REMOVAL (Specify)

23b. DATE THEREOF: 12-26-67

23c. NAME OF CEMETERY OR CREMATORY: K of P CEMETERY

23d. LOCATION (City or Town) (County) (State): RUSSELLSUILLE, ALA.

24. FUNERAL DIRECTOR: Ho. Co. Fit. of H. H. Witzke — ADDRESS: Elliot City

25a. REC'D BY REGISTRAR DATE: DEC 26 1967

25b. REGISTRAR'S SIGNATURE: Charles Jones

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16380

CERTIFICATE OF DEATH

16372

1. DECEASED-NAME (Type or print) First	Middle	Last	2o. DATE OF DEATH Month	Day	Year	2b. HOUR
Darwin	Lindsay	Moore	12	31	67	10:50 AM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
Male	Negro	8-22-67	4 mos. YRS.		

7o. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
Md.	U.S.A.		Anne Arundel County Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Pasadena, Md.	North Arundel Hospital		

13o. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☐ NO ☐	13e. STREET AND NUMBER
Md.	Anne Arundel	Pasadena		Box 498, Magothy Beh. Road.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Donald	L.	Moore	Barbara	Mae	Lee

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
NO	N/A	Patients Chart	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Status Thymicolymphaticus — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) Virus
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 273 x
DUE TO, OR AS A CONSEQUENCE OF (c) ? Virus Pneumonia

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☒ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I **certify** that (I) (this hospital) attended the deceased from Dec 29, 1967, to Dec 31, 1967, that (I) (we) last saw the deceased alive on Dec 31 1967, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. TIME Pronounced 10:50 Am on 12/31/67

22b. SIGNATURE	DEGREE	ATTENDING PHYS. ☒	MED. DIRECTOR ☐	STAFF PHYS. ☐	22c. DATE SIGNED
Max Frank MD					1-1-68

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Max Frank, M.D.	Arundel Medical Group, Glen Burnie

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town)	(County)	(State)
BURIAL	1/4/68	MT ZION Ch. Cem.	Magothy		Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Morton and Dyett Funeral Home	JAN 2 1968	Charles Jugg

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

7501677 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16381

CERTIFICATE OF DEATH

16373

1. **PLACE OF DEATH**
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 167 GREEN ST.

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ANNE ARUNDEL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS — 02.1
d. STREET ADDRESS: 167 GREEN ST
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First MARY — Middle M. — Last MUNROE

4. **DATE OF DEATH**: Month Dec. — Day 13 — Year 1967

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: MARCH 24, 1899
9. AGE (In years last Birthday): 68 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SECRETARY RET.
10b. KIND OF BUSINESS OR INDUSTRY: INSURANCE
11. BIRTHPLACE (County & State, or foreign country): ANNAPOLIS MD
12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: CHARLES GRAFTON MUNROE
14. MOTHER'S MAIDEN NAME: ANNIE GIRAULT

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. **INFORMANT** Address: ELIZABETH C. MUNROE #2

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac arrest — INTERVAL BETWEEN ONSET AND DEATH: instant.
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4330
(b): Arteriosclerotic cardiovascular disease — 6 yr.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Jan, 1960, to Dec, 1967, that (I) (we) last saw the deceased alive on 11/9 1967, and that death occurred at 2 A.M., from causes and on the date stated above.

22a. SIGNATURE: John Hedderman M.D. — ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/14/67
22c. PHYSICIAN'S NAME (Type): JOHN HEDDERMAN
22d. ADDRESS: FOREST DR ANNAPOLIS, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: DEC 15 1967
23c. NAME OF CEMETERY OR CREMATORY: ST. ANNES
23d. LOCATION (City or Town) (County) (State): ANNAPOLIS A.A. MD.

24. FUNERAL DIRECTOR: John M. Taylor Sons — ADDRESS: Annapolis, Md.
25a. REC'D BY REGISTRAR DATE: DEC 18 1967
25b. REGISTRAR'S SIGNATURE: [illegible]

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15(A)
30M REV. 1/68

16382

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

16374

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
ROY	S.	NEARY	December 31, 1967	1 10 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
MALE	WHITE	MARCH 5, 1910	57 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	9. COUNTY OF DEATH
Severn, Md.	U.S.A.		ANNE ARUNDEL CO. Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
MILLERSVILLE,	KNOLLWOOD NURSING HOME	Retired	Civil Service

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Anne Arundel	Gambrills	YES ☐ NO ☒	Box #156

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
HARRY		NEARY	LAURA		WHITEHEAD

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
NO ///////////	717 07 6672	Mrs. Helen L. Stach (daughter) Same As 13c

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Congestive heart failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 years

DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis, general & coronary — — years

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Diabetes mellitus

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from 29 Dec, 19 67, to 31 Dec, 19 67, that (I) (we) last saw the deceased alive on 29 Dec 1967, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Charles W. Kinzer	ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	2 Jan 1968

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Charles W. Kinzer	Annapolis, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	JAN. 3, 1968	Trinity Meth. Ch. Cem.	Odenton, A.A. Co., Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
R V Singleton	SINGLETON FUNERAL HOME GLEN BURNIE, MD.	DATE JAN 3 1968	J Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16383

CERTIFICATE OF DEATH

16375

1. **PLACE OF DEATH**
   a. COUNTY: Anne Arundel — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
   c. LENGTH OF STAY IN 1b: 10 days
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Anne Arundel
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Shady Side
   d. STREET ADDRESS: 0241
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Jerome — Middle: — Last: NICK

4. **DATE OF DEATH**: Month: December — Day: 20 — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Aug. 9, 1887

9. AGE (In years last birthday): 80 yrs.
   IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: William T. Nick

14. MOTHER'S MAIDEN NAME: Hattie Taylor

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No

16. SOCIAL SECURITY NO.:

17. INFORMANT: Leonard Nick — Address: Shadyside

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b) and (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): 4466 Pneumonia + uremia — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks
   DUE TO (b): Arteriosclerotic nephrosclerosis — 1 year
   Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
   DUE TO (c):

   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) ~~discharged~~ attended the deceased from Jan, 19 60, to Dec. 20, 19 67 that (I) ~~did~~ last saw the deceased alive on Dec. 20, 19 67, and that death occurred at 2:25 AM M, from causes and on the date stated above.

22a. SIGNATURE: Willard F. Smith M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 12/20/67

22c. PHYSICIAN'S NAME (Type): Willard F. Smith, MD.

22d. ADDRESS: Shady Side, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 12-23-67

23c. NAME OF CEMETERY OR CREMATORY: St. Matthews

23d. LOCATION (City or Town) (County) (State): Shadyside Md.

24. FUNERAL DIRECTOR: William Reese — ADDRESS: Anna, Md.

25a. REC'D BY REGISTRAR DATE: DEC 27 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

16384 16376

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/60

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pasadena
c. LENGTH OF STAY IN 1b: 18 years
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 256 Carroll Rd.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pasadena
d. STREET ADDRESS: 256 Carroll Rd.
a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HERMAN Middle NORWOOD Last Sr.

4. DATE OF DEATH: Month 12 Day 1 Year 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Dec. 9, 1887

9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): chauffeur

10b. KIND OF BUSINESS OR INDUSTRY: Steel Co.

11. BIRTHPLACE (County & State, or foreign country): Mt. Airy, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: John E. Norwood

14. MOTHER'S MAIDEN NAME: Clementine Gatrell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 212-07-55454

17. INFORMANT: Herman Norwood, Jr., 9112 Walden Rd., Silver Spri Address: Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CARDIO-RESPIRATORY FAILURE — INTERVAL BETWEEN ONSET AND DEATH: SUDDEN

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b) HEPATOMA (PRIMARY CANCER LIVER) — 3 MONTHS

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): ARTERIOSCLEROTIC HEART DISEASE

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (~~this hospital~~) attended the deceased from JUNE 19, 1961 to DEC 1, 1967, that (I) (~~we~~) last saw the deceased alive on 11-1-1967, and that death occured at 9 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Arthur Lankford Jr. M.D.

22c. PHYSICIAN'S NAME (Type): ARTHUR LANKFORD, JR., M.D.
2904 MOUNTAIN ROAD
PASADENA, MD. 21122

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 12-1-67

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 12-4-1967

23c. NAME OF CEMETERY OR CREMATORY: Druid Ridge Cemetery

23d. LOCATION (City, town or county) (State): Pikesville, Baltimore, Md.

24 FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: George J. Gonce-4001 Ritchie Hgwy., Baltimore

25a. REC'D BY REGISTRAR DATE: DEC 5 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16385

CERTIFICATE OF DEATH

16377

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH a. COUNTY A.A. MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD. b. COUNTY Balt.
b. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town) Glen Burnie c. LENGTH OF STAY IN 1b 1 hr 45 min	c. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town) Baltimore 30-4
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel Hospital	d. STREET ADDRESS 3133 Dillon St e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Edith	A	Novak	Dec.	3	1967

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
F	W		11-30-00	67 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Homemaker	none	W. Virginia	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH

DUE TO (b) ASHD

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c)

4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

CHF

3

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. I certify that (I) (this hospital) attended the deceased from 12/3/67, 19 3p, to 12/3/67, 19___, that (I) (we) last saw the deceased alive on 12/3/67, 19___, and that death occurred at 5:00 M, from causes and on the date stated above.

22a. SIGNATURE J.B. Ramirez M.D.	ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22b. DATE SIGNED 12/4/67
22c. PHYSICIAN'S NAME (Type) J.B. RAMIREZ	22d. ADDRESS 3521 ANNAPOLIS RD Balto 27 Md	

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12-7-67	23c. NAME OF CEMETERY OR CREMATORY Ebenezer	23d. LOCATION (City or Town) Md (County) (State)
24. FUNERAL DIRECTOR Thelma A. Hoffman	ADDRESS 3218 Sudem St.	25a. REC'D BY REGISTRAR DATE DEC 8 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16386

CERTIFICATE OF DEATH

16378

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. **PLACE OF DEATH**
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): GLEN BURNIE
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): NORTH ARUNDEL CONVALESCENT CENTER

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BALTIMORE 21218
d. STREET ADDRESS: 3805 OLD YORK RD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. **NAME OF DECEASED** (Type or print): First MARY — Middle — Last O'BRIEN

4. **DATE OF DEATH**: Month 12 — Day 12 — Year 67

5. SEX: FEM

6. COLOR OR RACE: WH

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: 11-24-1888

9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): TIMEKEEPER

10b. KIND OF BUSINESS OR INDUSTRY: BALTO-TRANSIT CO.

11. BIRTHPLACE (County & State, or foreign country): WILMINGTON, DELA.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JAMES TAYLOR

14. MOTHER'S MAIDEN NAME: SARAH BONER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 213-10-9832

17. **INFORMANT**: MRS. AGNES CURRENS — Address: (SAME)

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Left Ventricular failure — INTERVAL BETWEEN ONSET AND DEATH: hours
DUE TO (b): Cerebro vascular accident — months
DUE TO (c): Generalized arteriosclerosis — years.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
331 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Congestive heart failure

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 10/30, 1967, to 12/12, 1967 that (I) (we) last saw the deceased alive on 12/12 1967 and that death occurred at 6:15 AM, from causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. — ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 12/12/67

22c. PHYSICIAN'S NAME (Type): MAX C FRANK MD

22d. ADDRESS: 425 SE Kitzline Hwy Edgemere Md 21063

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 12/15/67

23c. NAME OF CEMETERY OR CREMATORY: New Cathedral

23d. LOCATION (City or Town) (County) (State): Baltimore, Maryland

24. FUNERAL DIRECTOR: H.W. Jenkins & Sons Co. — ADDRESS: 4905 York Road Baltimore, Md. 21212

25a. REC'D BY REGISTRAR DATE: DEC 13 1967

25b. REGISTRAR'S SIGNATURE: [signature]

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

16387

CERTIFICATE OF DEATH

17886

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LAUREL
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): LAUREL CHILDREN'S CENTER

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ~~PR. GEORGES~~ ~~ANN ARUNDAL~~
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~LAUREL~~ Hillcrest Heights
d. STREET ADDRESS: ~~2822 NONE~~ CURTIS DRIVE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
MICHAEL	GORDON	OIHUS	12	31	1967

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
M	W		12-30-58	9 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
NONE	NONE	NORTH DAKOTA	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
GORDON OIHUS	LEONA ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
NO	NONE	MEDICAL CHART

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): PNEUMONIA — INTERVAL BETWEEN ONSET AND DEATH: 2 Mo 8d

491X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): ASPIRATION

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): MENTAL RETARDATION; CONVULSIVE DISORDER, SPASTIC QUADRIPLEGIA

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, ferm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. **I certify** that (I) (this hospital) attended the deceased from 10-22, 1967 to 12-30, 1967, that (I) (we) last saw the deceased alive on 12-30 1967, and that death occured at 10:35 P.M. from the causes and on the date stated above.

22a. SIGNATURE	ATTENDING PHYS. ☐	MED. DIRECTOR ☐	STAFF PHYS. ☒	22b. DATE SIGNED
Loretta K. Gilmore M.D.				12-31-67

22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS
LORETTA K. GILMORE	LAUREL CHILDREN'S CENTER, LAUREL, MD

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
Burial	1-5-68	Grafton Cemetery	Grafton N. Dakota

24 FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
De Witt Davidson	Laurel Md	JAN 12 1968	Clerk or Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16388

CERTIFICATE OF DEATH

16380

1. **PLACE OF DEATH**
   a. COUNTY: Anne Arundel — MARYLAND
   b. CITY OR TOWN (If outside corparate limits, write RURAL and give nearest town): Glen Burnie
   c. LENGTH OF STAY IN 1b: 5 days
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): North Arundel Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: AA
   c. CITY OR TOWN (If outside corparate limits, write RURAL and give nearest town): Linthicum Heights
   d. STREET ADDRESS: 305 Viewing Ave.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Katie ~~Catherine~~ — Middle: E. — Last: Parker

4. **DATE OF DEATH**: Month: December — Day: 15 — Year: 1967

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 3-12-82

9. AGE (In years last birthday): 85 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? US A

13. FATHER'S NAME: John K. Brown

14. MOTHER'S MAIDEN NAME: Annie Hundley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.

17. **INFORMANT** Address: Mrs. Lillian M. Przylepa, 305 Viewing Avenue

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: 3 weeks
DUE TO
(b): Generalized Carcinomatosis — 6 months
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

1992

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Arteriosclerosis — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) ~~(this hospital)~~ attended the deceased from December 10, 1967, to December 15, 1967, that (I) ~~(we)~~ last saw the deceased alive on December 15, 1967, and that death occurred at 10:25 P M, from causes and on the date stated above.

22a. SIGNATURE: E. Frederick Shipley — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: December 16, 1967

22c. PHYSICIAN'S NAME (Type): E. Frederick Shipley

22d. ADDRESS: 529 Camp Meade Road Linthicum, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 12-19-1967

23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery

23d. LOCATION (City or Town) (County) (State): Baltimore County, Maryland

24. FUNERAL DIRECTOR ADDRESS: Howard H. Hubbard, 4107 Wilkens Ave. 21229

25a. REC'D BY REGISTRAR DATE: DEC 22 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16389 16381

1

1. DECEASED-NAME (Type or print) First: ELLA Middle: CATHERINE Last: PARKS
2a. DATE OF DEATH Month: Dec Day: 22 Year: 1967
2b. HOUR: 7:30 AM
3. SEX: Female
4. RACE: White
5. DATE OF BIRTH: Sept 19 1879
6. AGE (In years last birthday): 88 YRS. IF UNDER 1 YEAR: MONTHS / DAYS. IF UNDER 24 HRS.: HOURS / MIN
7a. BIRTHPLACE (State or foreign country): Churchtown Md.
7b. CITIZEN OF WHAT COUNTRY?: U S A
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. COUNTY OF DEATH: Anne Arundel Md.
10. CITY OR TOWN OF DEATH: Lothian MD
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address):
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): housewife
12b. KIND OF BUSINESS OR INDUSTRY:
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MD
13b. COUNTY: AA
13c. CITY OR TOWN: DEALE MD
13d. INSIDE CITY LIMITS? YES ☐ NO ☐
13e. STREET AND NUMBER:
14. FATHER'S NAME First: HEZERIAH Middle: Last: Fisher
15. MOTHER'S MAIDEN NAME First: Sara Elizabeth Middle: Rogers Last: Ward
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)
(If yes give war or dates of service)
16b. SOCIAL SECURITY NO.
17. INFORMANT: Alvin Parks Address: Deale MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Stroke — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: weeks
334x
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b): Cerebral Arteriosclerosis — years
DUE TO, OR AS A CONSEQUENCE OF (c): Generalized Arteriosclerosis — years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
NONE

19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES ☐ NO ☒
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work ☐ Not while at work ☐
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from 12/18/67, 19____, to 12/21/67, 19____, that (I) (we) last saw the deceased alive on 12/21/67 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Charles H Wirth Jr. DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22c. DATE SIGNED: 12/23/67
22d. PHYSICIAN'S NAME (Type): Charles H. Wirth MD
22e. ADDRESS: Lothian Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 12-24-67
23c. NAME OF CEMETERY OR CREMATORY: St James
23d. LOCATION (City or Town) (County) (State): Tracys AA MD
24. FUNERAL DIRECTOR ADDRESS: Bernard Hardesty Edgewood Md
25a. REC'D BY REGISTRAR DATE: DEC 29 1967
25b. REGISTRAR'S SIGNATURE: [illegible] Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (M)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16390

CERTIFICATE OF DEATH

16382

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 81 yr
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Galesville 02.1
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Edith — Middle: Glover — Last: PEAKE

4. DATE OF DEATH: Month: December — Day: 11 — Year: 19 67

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: October 15, 1886

9. AGE (In years last birthday): 81 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Galesville Maryland

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: William Glover

14. MOTHER'S MAIDEN NAME: Sally Parrish

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): —
(If yes give wor or dotes of service): —

16. SOCIAL SECURITY NO.: 212 28 3362

17. INFORMANT: Raymond Peake — Address: Galesville Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
463 X
IMMEDIATE CAUSE (a): Multiple Pulmonary Emboli — INTERVAL BETWEEN ONSET AND DEATH: 1 Hour
DUE TO
Conditions, if ony, which gove rise to immediate couse (a), stoting the underlying couse last.
(b): Probable THROMBO-phlebitis Lt Leg
DUE TO
(c): FX Lt Hip

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): FX Femoral Neck Left

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.): Fell in Yard at Home

20c. TIME OF INJURY Month, Day, Year: 11-25 19 67 — Hour o.m. p.m.

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town): Galesville — (County): AA — (State): Md

21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19___, thot (I) (we) last saw the deceased alive on Dec 11 1967, and that death occurred at 10:15 P.M., from causes and on the date stated above.

22a. SIGNATURE: [signature]
M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 1

22c. PHYSICIAN'S NAME (Type):

22d. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 12-14-67

23c. NAME OF CEMETERY OR CREMATORY: Woodfield

23d. LOCATION (City or Town): Galesville — (County): AA — (State): Md.

24. FUNERAL DIRECTOR: Bernard O. Hardesty — ADDRESS: Galesville, Md.

25a. REC'D BY REGISTRAR (DATE): DEC 18 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

16391

CERTIFICATE OF DEATH

16383

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Orchard Beach
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 7812 Waterview Drive 21226

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Orchard Beach
d. STREET ADDRESS: 7812 Waterview Drive 21226
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Frederick Middle Henry Last Pepersack

4. DATE OF DEATH: Month December Day 15, Year 19 67

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: June 29, 1898
9. AGE (In years last birthday): 69 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machinist
10b. KIND OF BUSINESS OR INDUSTRY: Int. Bedding Co.
11. BIRTHPLACE (County & State, or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A/

13. FATHER'S NAME: Frederick Wm. Pepersack
14. MOTHER'S MAIDEN NAME: Lena Meyer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.:
17. INFORMANT Address: Mrs. Margaret Gunther 7825 Bridge Dr. 21226

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: 2 years
4500
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): none

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from Mar. 1, 1954, to December 15, 1967, that (I) (~~we~~) last saw the deceased alive on December 10 1967, and that death occurred at 5:54 M, from the causes and on the date stated above.

22a. SIGNATURE: R. M. McLaughlin — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/15/67
22c. PHYSICIAN'S NAME (Type): R. M. McLaughlin
22d. ADDRESS: 3708 Mountain Rd. Pasadena, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12/18/67
23c. NAME OF CEMETERY OR CREMATORY: Meadowridge Memorial Park
23d. LOCATION (City, town or county) (State): Howard Co. Md.

24. FUNERAL DIRECTOR: McCully F. H.
ADDRESS: 237 Patapsco Ave. 21225
25a. REC'D BY REGISTRAR DATE: DEC 18 1967
25b. REGISTRAR'S SIGNATURE: Charles Jones

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16392

CERTIFICATE OF DEATH

17887

1. PLACE OF DEATH
a. COUNTY: AA — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): DEALE
c. LENGTH OF STAY IN 1b: 15 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address)

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MD
b. COUNTY: AA
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Deale 02 1
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First James Middle Moody Lost Phipps
4. DATE OF DEATH: Month Dec. Day 20 Year 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: ~~Feb.~~ 7/16/82
9. AGE (In years last birthday): 85 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waterman
10b. KIND OF BUSINESS OR INDUSTRY: Sea-food
11. BIRTHPLACE (County & State, or foreign country): Brodwater Deale Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME
14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service)
16. SOCIAL SECURITY NO.
17. INFORMANT — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: Few days
DUE TO (b): Carcinoma of lung — 6 months
DUE TO (c):
Conditions, if ony, which gove rise to immediote couse (a), stoting the underlying couse last. 163 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify thot (I) (this hospital) attended the deceased from Jan, 1960, to Dec 20, 1967, that (I) (we) last saw the deceased alive an Dec 19 1967 and that death accurred at 4.4 M, from causes and an the date stated abave.

22a. SIGNATURE: Willard F. Smith — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/20/67
22c. PHYSICIAN'S NAME (Type): Willard F. Smith MD
22d. ADDRESS: Shady Side, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12/22/67
23c. NAME OF CEMETERY OR CREMATORY: Woodfield
23d. LOCATION (City or Town) (County) (State): Edgewater AA Md

24. FUNERAL DIRECTOR: Bernard Hardesty — ADDRESS: Galesville Md
25a. REC'D BY REGISTRAR: JAN 18 1968
25b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16393 16384

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. **PLACE OF DEATH**
   a. COUNTY: Anne Arundel — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Bay Manor Nursing Home

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Anne Arundel
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pasadena
   d. STREET ADDRESS: Rt.#2, Box #214 Belhaven Beach
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. **NAME OF DECEASED** (Type or print): First: HERMAN — Middle: W. — Last: PLATZKE

4. **DATE OF DEATH**: Month: DECEMBER — Day: 28, — Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Aug. 14, 1880

9. AGE (In years last birthday): 87 yrs.
   IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Carpenter

10b. KIND OF BUSINESS OR INDUSTRY: Construction

11. BIRTHPLACE (County & State, or foreign country): Dansi, Germany

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: (unknown) Platzke

14. MOTHER'S MAIDEN NAME: (unknown)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service): ////////////

16. SOCIAL SECURITY NO.: 212 07 1783

17. **INFORMANT** Address: Charles R. Platzke (son) Same As #2

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonia Right lower lobe — INTERVAL BETWEEN ONSET AND DEATH: 1 week
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)
491x

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arteriosclerotic cardiovascular disease

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from ____, 19__, to ____, 19__, that (I) (we) last saw the deceased alive on Dec 27 1967, and that death occurred at ____ M, from causes and on the date stated above.

22a. SIGNATURE: Ray M Smith — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: Dec 30, 1967

22c. PHYSICIAN'S NAME (Type): Ray M. Smith

22d. ADDRESS: Severna Park, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Dec. 30/67

23c. NAME OF CEMETERY OR CREMATORY: Glen Haven Memorial Park

23d. LOCATION (City or Town) (County) (State): Glen Burnie, Maryland

24. FUNERAL DIRECTOR: Singleton Funeral Home — ADDRESS: Glen Burnie, Md

25a. REC'D BY REGISTRAR DATE: JAN 4 1968

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16394

CERTIFICATE OF DEATH

16385

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 71 Conduit Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Alexander — Middle: Hamilton — Last: POLK

4. DATE OF DEATH: Month: December — Day: 26 — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 20, 1889

9. AGE (In years last birthday): 78 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RET. ENGINEER

10b. KIND OF BUSINESS OR INDUSTRY: DEPT OF US ARMY

11. BIRTHPLACE (County & State, or foreign country): ASHVILLE, N Carolina Maryland

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: FRANCIS DEVERUX POLK

14. MOTHER'S MAIDEN NAME: MARGARET CALLAWAY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: MARGARET E. POLK — Address: #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: days
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b): Carcinoma of Larynx — Months
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 12/1, 1967, to 12/26, 1967, that (I) (we) last saw the deceased alive on 12/26 1967, and that death occurred at 7:15 P.M. from causes and on the date stated above.

22a. SIGNATURE: Gordon Church — M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 12/27/67

22c. PHYSICIAN'S NAME (Type): Gerard Church

22d. ADDRESS: 121 Coldspring St, Baltimore MD

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 12/29/1967

23c. NAME OF CEMETERY OR CREMATORY: LOUDON PARK CEM.

23d. LOCATION (City or Town) (County) (State): BALTIMORE MD

24. FUNERAL DIRECTOR: JOHN M. TAYLOR & SONS — ADDRESS: ANNAPOLIS MD

25a. REC'D BY REGISTRAR DATE: DEC 29 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16395

CERTIFICATE OF DEATH

16386

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 4 Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Severna Park 02,1
d. STREET ADDRESS: 133 Round Bay Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Miriam — Middle: Toombs — Last: RAKER

4. DATE OF DEATH: Month: December — Day: 16 — Year: 19 67

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: February 20, 1916

9. AGE (In years last birthday): 51 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Copywriter

10b. KIND OF BUSINESS OR INDUSTRY: Dept. Store

11. BIRTHPLACE (County & State, or foreign country): Illinois

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Claude H Toombs

14. MOTHER'S MAIDEN NAME: Cleo Albin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service)

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Fredrick Ra ker — Address: - Above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Liver Failur acute & chronic
DUE TO
(b): Cancer Cirrhosis
DUE TO
(c): —
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
5811
INTERVAL BETWEEN ONSET AND DEATH: 3 weeks

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from ____, 19____, to ____, 19____, that (I) (we) last saw the deceased alive on December 16 1967, and that death occurred at 9:50 a.m. from causes and on the date stated above.

22a. SIGNATURE: Ray M Smith — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: Dec.

22c. PHYSICIAN'S NAME (Type): RAY M. SMITH

22d. ADDRESS: Severna Park, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): CREMATION

23b. DATE THEREOF: 12-16-67

23c. NAME OF CEMETERY OR CREMATORY: LEE CREMATORY

23d. LOCATION (City or Town) (County) (State): WASHINGTON D.C.

24. FUNERAL DIRECTOR: ROBERT S BARRANCO. PARK. MD
ADDRESS: SEVERNA

25a. REC'D BY REGISTRAR
DATE: DEC 20 1967

25b. REGISTRAR'S SIGNATURE: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16396

CERTIFICATE OF DEATH

16387

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 5 Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie 02-1
d. STREET ADDRESS: 102 Woods Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: William — Middle: Henry — Last: REDELIUS

4. DATE OF DEATH: Month: December — Day: 28 — Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 20, 1904

9. AGE (In years last birthday): 63 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: General Motors

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Frederick Redelius

14. MOTHER'S MAIDEN NAME: Hermie Higdon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 215-05-0892

17. INFORMANT: Address: Mary N. Redelius, same as 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis.
DUE TO
(b):
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
332X
INTERVAL BETWEEN ONSET AND DEATH: Days.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
V

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 12/24, 1967, to 12/27, 1967, that (I) (we) last saw the deceased alive on December 28 1967, and that death occurred at 2:10 a. m. M, from causes and on the date stated above.

22a. SIGNATURE: Gerard Rhuel — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 12/29/67.

22c. PHYSICIAN'S NAME (Type): Gerard Elwell

22d. ADDRESS: 121 Cathedral St, Annapolis Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 1 Jan. 68

23c. NAME OF CEMETERY OR CREMATORY: Meadowridge Memorial

23d. LOCATION (City or Town) (County) (State): Elkridge, Howard, Md.

24. FUNERAL DIRECTOR ADDRESS: Kirkley Funeral Home, Glen Burnie, Md. 21061

25a. REC'D BY REGISTRAR DATE: JAN 2 1968

25b. REGISTRAR'S SIGNATURE: J Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16397

CERTIFICATE OF DEATH

16388

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Millersville
c. LENGTH OF STAY IN 1b: 10-WEEKS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Mollewood Manor

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MD
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Severna Park
d. STREET ADDRESS: 186 Carroll Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Annie — Middle: Louise — Last: Reid

4. DATE OF DEATH: Month: 12 — Day: 17 — Year: 19 67

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: 01/11/1891

9. AGE (In years last birthday): 76 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (County & State, or foreign country): Va

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: WM THOMAS PUGH

14. MOTHER'S MAIDEN NAME: WAUGH

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 227-01-7804

17. INFORMANT: MABLE SWINDELL — Address: AS ABOVE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): C.V.A. & Rt hemipleged
DUE TO (b): A.C.V.D.
DUE TO (c): Senility
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4221

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1967, 19__, to 1967, 19__, that (I) (we) last saw the deceased alive on 12-16-67, 19__, and that death occurred at 5P M, from causes and on the date stated above.

22a. SIGNATURE: Robert R. Hahn — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 12-17-67

22c. PHYSICIAN'S NAME (Type): Robert R. HAHN

22d. ADDRESS: Severna Park Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 12/20/67

23c. NAME OF CEMETERY OR CREMATORY: Oakwood Cemetery

23d. LOCATION (City or Town) (County) (State): Richmond, Virginia

24. FUNERAL DIRECTOR: Raymond C. Fink — ADDRESS: Glen Burnie, Md.

25a. REC'D BY REGISTRAR — DATE: DEC 19 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

1

FOR STATE HEALTH DEPT.

16398

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16389

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: A.A
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville 021
d. STREET ADDRESS: Rt. 2, Box 606A
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CLEMENTINE Middle E. Last REIER ~~RAIER~~

4. DATE OF DEATH: Month December Day 9, Year 19 67

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 4/9/1930

9. AGE (In years lost birthday): 37 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (State or foreign country): Mass.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Walter Galenski

14. MOTHER'S MAIDEN NAME: Anna Zalesuski

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give wor or dotes of service)

16. SOCIAL SECURITY NO.: 030-22-6049

17. INFORMANT: Edward W. Reier (above address) (Husband)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Fatty Alteration of Liver
DUE TO
(b):
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
581.0
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☒ Partial, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Werner U. Spitz M.D.

EXAMINER'S NAME (Type): Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐
Address (Street, city, town, or county)

22. DATE SIGNED: 12/10/67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 12/13/67

23c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cem.

23d. LOCATION (City or Town) (County) (State): Colmar Man or, Md.

24. FUNERAL DIRECTOR: Nalley's Funeral Home Inc. ADDRESS: Mt. Rainier, Maryland

25a. REC'D BY REGISTRAR DATE: DEC 18 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15ME (5) 6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

16399

CERTIFICATE OF DEATH

16390

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 5-63

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): West River
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Residence West River (Rural)

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural West River
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ETHEL — Middle MARIE — Last RENEHAN

4. DATE OF DEATH: Month Dec. — Day 27 — Year 19 67

5. SEX: female — 6. COLOR OR RACE: Cau. — 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ — 8. DATE OF BIRTH: July 29, 1897 — 9. AGE (In years last birthday): 70 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): telephone operator
10b. KIND OF BUSINESS OR INDUSTRY: public utilities
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Bernard Norris
14. MOTHER'S MAIDEN NAME: Lelia Hayden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): no
16. SOCIAL SECURITY NO.: 577 011 617
17. INFORMANT — Address: James J. Renehan - same as #2 above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: few hours

DUE TO (b): Arteriosclerotic heart disease — years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes — Influenza

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Jan, 1962 to Dec 27, 1967, that (I) (we) last saw the deceased alive on Dec 26 1967, and that death occurred at 4 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Willard F Smith M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/28/67
22c. PHYSICIAN'S NAME (Type): Willard F. Smith, MD
22d. ADDRESS: Shady Side, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Dec. 30, 1967
23c. NAME OF CEMETERY OR CREMATORY: Our Lady of Sorrows
23d. LOCATION (City, town or county) (State): Owensville A.A. Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Beverley E. Hopping
ADDRESS: Annapolis, Md.
HOPPING FUNERAL HOME

25a. REC'D BY REGISTRAR DATE: JAN 2 1968
25b. REGISTRAR'S SIGNATURE: [illegible] Judge

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

16400 — 16391

1. **PLACE OF DEATH**
   a. COUNTY: ANNE ARUNDEL — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): PASADENA
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): RT. 2 BOX 419

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: MARYLAND — b. COUNTY: ANNE ARUNDEL
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): PASADENA
   d. STREET ADDRESS: RT. 2 BOX 419
   a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First CHARLES — Middle V. — Last ROCK

4. **DATE OF DEATH**: Month DEC — Day 30 — Year 1967

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 5-10-94

9. AGE (In years last birthday): 73 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): TEACHER, RETIRED

10b. KIND OF BUSINESS OR INDUSTRY: BALTO. CITY

11. BIRTHPLACE (County & State, or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: CHARLES V. ROCK

14. MOTHER'S MAIDEN NAME: ANNIE E. MC DERMOTT

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): YES — (If yes give war or dates of service): WW I

16. SOCIAL SECURITY NO.: 214405569 J2

17. INFORMANT — Address: ELLA A. ROCK, Rt. 2 Box 419, Pasadena, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GENERALIZED CARCINOMATOSIS — INTERVAL BETWEEN ONSET AND DEATH: 6 MO.

177X

Conditions, if any, which gave rise to immadiata cause (a), stating tha underlying cause last.

DUE TO (b) CARCINOMA PROSTATE — 4 YRS.

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter natura of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (~~His hospital~~) attended the deceased from JULY 30, 1963 to DEC 30, 1967, that (I) (~~we~~) last saw the deceased alive on DEC 28 1967, and that death occured at 4:30 P.M, from the causes and on the date stated above.

22a. SIGNATURE: Arthur Lankford Jr. M.D. M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 12-30-67

22c. PHYSICIAN'S NAME (Type): ARTHUR LANKFORD JR. MD

22d. ADDRESS: 2934 MOUNTAIN RD PASADENA, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 1-1-68

23c. NAME OF CEMETERY OR CREMATORY: DRUID RIDGE CEMETERY

23d. LOCATION (City, town or county) (State): BALTIMORE, MD.

24 FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: HOWARD H. HUBBARD 4107 WILKENS AVE. 21229

25a. REC'D BY REGISTRAR DATE: JAN 3 1968

25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

16401

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16392

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, ar removal, and in any event, within 72 hours after death.

VR A15 (1)
30M REV. 1-68

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
Charles	W.	Ross	12	25	67	M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last Birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
Male	Colored	1/15/27	40 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
Maryland	U.S.A.		Anne Arundel Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Annapolis	C.G. General Hosp	Retired	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER
37 Camp Dr.	A.A.	Annapolis		51 First St.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
John	Walter	Ross	Emma	Green	

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
Yes	219-12-3264	Irene Ross	Anna. Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4330
DUE TO, OR AS A CONSEQUENCE OF (b) Cardiac failure
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from 8-3-67, 19___, to 12-25, 19 67, that (I) (we) last saw the deceased alive an ___ 19___, and that in (my) (our) apinion death accurred an the date and haur and fram the causes stated abave, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
A. T. Allen	ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	12-26-67

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
A.T. ALLEN	

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town)	(County)	(State)
Burial	12/28/67	St. Mary's	Annapolis	A.A.	Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. RECD BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
William Tesse, Jr.	Anna. Md.	DEC 27 1967	

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1 and 2 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health priar to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16402 Item 7 Film G396 1/5/68 kk

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16393

1. PLACE OF DEATH
   a. COUNTY: Anne Arundel — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~Baltimore~~ Glen Burnie
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): North Arundel Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: A.A.
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 02-1
   d. STREET ADDRESS: 333 Crosswell Rd.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First FRANK Middle H Last ROWE

4. DATE OF DEATH: Month December Day 29 Year 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 8/1909

9. AGE (In years last birthday): 58 yrs.
   IF UNDER 1 YEAR: Months / Days
   IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mer Marine

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Walter Rowe

14. MOTHER'S MAIDEN NAME: Unk

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
   (If yes give wor or dotes of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Family — Address: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): ~~Exsanguination~~ 977X
   DUE TO (b): Laceration of the arm
   DUE TO (c):
   Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

   INTERVAL BETWEEN ONSET AND DEATH:

   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES XX NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Subject found with extensive lacerations and suicide not

20c. TIME OF INJURY Month, Day, Year: Hour xxx p.m. 12 29 1967

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town) Baltimore (County) A. A. (State) Md.

21. I certify thot I took charge of the remoins described above, held an Autapsy ☒, Inspectian ☐, Inquiry ☐, and in my opinion deoth resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined monner ☐

ACTUAL SIGNATURE: Edward F. Wilson M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐

EXAMINER'S NAME (Type): Edward F. Wilson, M.D.

Address (Street, city, town, or county): December 30, 1967

22. DATE SIGNED

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 1/2/68

23c. NAME OF CEMETERY OR CREMATORY: Glen Haven Cem

23d. LOCATION (City or Town) Glen Burnie (County) AA Co (State) Md

24. FUNERAL DIRECTOR: McCulley F. H. — ADDRESS: 737 Potapsco Ave 21225

25a. REC'D BY REGISTRAR DATE: JAN 2 1968

25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16403

CERTIFICATE OF DEATH

16394

1. PLACE OF DEATH
a. COUNTY: A. A. Co. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): ANNAPOLIS NURSING HOME

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MD. — b. COUNTY: A.A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS — 02.1
d. STREET ADDRESS: 314 GLEN AVE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: EFFIE — Middle: MAY — Last: SANDS
4. DATE OF DEATH: Month: 12 — Day: 9 — Year: 1967
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: 5-30-1884
9. AGE (In years last birthday): 83 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CIVIL SERVICE
10b. KIND OF BUSINESS OR INDUSTRY: U.S. GOVT.
11. BIRTHPLACE (County & State, or foreign country): ANNAPOLIS, MD.
12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: JAMES FREEMAN
14. MOTHER'S MAIDEN NAME: EMELINE JONES

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes give war or dates of service): —
16. SOCIAL SECURITY NO.:
17. INFORMANT: NORMAN E. SANDS — Address: #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acquired Hemmorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 Hrs.
DUE TO
(b): Carcinoma of the Cervix (for advanced) — 5 yr.
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 171X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan 1967, 19__, to Dec 9, 1967 that (I) (we) last saw the deceased alive on 12/9/1967, and that death occurred at __M, from causes and on the date stated above.

22a. SIGNATURE: Albert L Anderson M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 12/9/67
22c. PHYSICIAN'S NAME (Type): ALBERT L ANDERSON M.D. — 22d. ADDRESS: 44 South Gate Linwood MD

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL — 23b. DATE THEREOF: 12-12-67 — 23c. NAME OF CEMETERY OR CREMATORY: CEDAR BLUFF — 23d. LOCATION (City or Town) (County) (State): HUNAPOLIS A.A. MD.

24. FUNERAL DIRECTOR: John M. Taylor & Sons — ADDRESS: Annapolis, Md. — 25a. REC'D BY REGISTRAR DATE: DEC 14 1967 — 25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 25M 1/67

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

16404

CERTIFICATE OF DEATH

16395

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pasadena, Md.
c. LENGTH OF STAY IN 1b: 14 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 9 Winding Woodsway

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pasadena 02.1
d. STREET ADDRESS: 9 Winding Woodsway
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: PAUL — Middle: F. — Last: SCHAFER

4. DATE OF DEATH: Month: December — Day: 14 — Year: 19 67

5. SEX: male

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 21 Oct 1924

9. AGE (In years last birthday): 43 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Pipefitter

10b. KIND OF BUSINESS OR INDUSTRY: F.M.M. Inc. Co.

11. BIRTHPLACE (County & State, or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Paul H. Schafer

14. MOTHER'S MAIDEN NAME: Antoinie Rosenboom

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no
(If yes give war or dates of service): ----------

16. SOCIAL SECURITY NO.: 216-20-7305

17. INFORMANT — Address: Pearl F. Schafer - Wife - Same as # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Pneumonia	2 days
DUE TO (b)	Anemia	3 mos
DUE TO (c)	CA of Rectum	18 mos

154 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from JAN, 19 66 to DEC, 19 67 that (I) (~~was~~) last saw the deceased alive on DEC 13 19 67, and that death occurred at 4 P.M. from the causes and on the date stated above.

22a. SIGNATURE: C. Earl Hill M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 12-15-67

22c. PHYSICIAN'S NAME (Type): C. Earl Hill, M. D.

22d. ADDRESS: 395 Ft. Smallwood Rd., Pasadena, Md. 2112

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 18 Dec. 1967

23c. NAME OF CEMETERY OR CREMATORY: Glen Haven Memorial Pk.

23d. LOCATION (City, town or county) (State): Glen Burnie, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE Robert Purse — **ADDRESS**: Singleton Funeral Home/ Glen Burnie, Md.

25a. REC'D BY REGISTRAR DATE DEC 18 1967

25b. REGISTRAR'S SIGNATURE Charles Judge

1

16405

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16396

M

1. PLACE OF DEATH a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: Maryland b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sherwood Forest 02-1
d. STREET ADDRESS: 715 Robin Hill
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print) First: Frank Middle: Lysander Last: SCOTT
4. DATE OF DEATH Month: December Day: 23 Year: 1967
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: October 21, 1883
9. AGE (In years last birthday): 84 yrs. IF UNDER 1 YEAR Months / Days; IF UNDER 24 HRS. Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): BUYER DEPT STORE
10b. KIND OF BUSINESS OR INDUSTRY: DEPT STORE RETAIL
11. BIRTHPLACE (County & State, or foreign country): Iowa
12. CITIZEN OF WHAT COUNTRY? U. S.
13. FATHER'S NAME: DAVID H. SCOTT
14. MOTHER'S MAIDEN NAME: MARIA McCULLOUGH
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service): -
16. SOCIAL SECURITY NO.: 212-09-9415
17. INFORMANT: F. BERTRAM SCOTT Address: #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 4 days

4201

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerosis — many years
DUE TO (c): - - - - - - - - - - - - - - - - - -

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Ileus due to I (a) above. Septicemia due to ileus.
19. WAS AUTOPSY PERFORMED? YES xx NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m.
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Aug 19, 1966, to Dec 23 1967, that (I) (we) last saw the deceased alive on Dec 23 1967, and that death occurred at 7:22 P from causes and on the date stated above.

22a. SIGNATURE: Charles W Kinzer M.D. ATTENDING PHYS. xx MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Dec 24, 1967
22c. PHYSICIAN'S NAME (Type): Charles W. Kinzer, M. D.
22d. ADDRESS: 16 Murray Avenue, Annapolis, Maryland 21401

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 12/27/1967
23c. NAME OF CEMETERY OR CREMATORY: PINE GROVE UNITED BRETHERN
23d. LOCATION (City or Town) (County) (State): RAYSVILLE MD
24. FUNERAL DIRECTOR: JOHN M TAYLOR & SON ADDRESS: ANNAPOLIS MD
25a. REC'D BY REGISTRAR DATE: DEC 27 1967
25b. REGISTRAR'S SIGNATURE: J Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4) 25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

16406 — 16397

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: Theodore	Middle: M.	Last: Seal	2a. DATE OF DEATH Month: 12	Day: 29	Year: 67
2b. HOUR	2:00 PM					
3. SEX	Male					
4. RACE	White					
5. DATE OF BIRTH	10/28/16					
6. AGE (In years last birthday)	51 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN			
7a. BIRTHPLACE (State or foreign country)	Virginia					
7b. CITIZEN OF WHAT COUNTRY?	USA					
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]						
9. COUNTY OF DEATH	Anne Arundel Md.					
10. CITY OR TOWN OF DEATH	Crownsville					
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	Crownsville State Hosp.					
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	Railroad Engineer					
12b. KIND OF BUSINESS OR INDUSTRY	----------					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	Maryland					
13b. COUNTY	—					
13c. CITY OR TOWN	Baltimore					
13d. INSIDE CITY LIMITS? YES [X] NO [ ]						
13e. STREET AND NUMBER	5605 Denwood Avenue					
14. FATHER'S NAME First	Theodore	Middle: M.	Last: Seal			
15. MOTHER'S MAIDEN NAME First	Annie	Middle	Last: Hicks			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)	No					
16b. SOCIAL SECURITY NO.	Unknown					
17. INFORMANT Address	Hospital Records, Crownsville Maryland					

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Septicemia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
609X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(b) Urinary Tract Infection
DUE TO, OR AS A CONSEQUENCE OF
(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Hypertension, Peptic Ulcer

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State	

22a. **I certify** that ~~I~~ (this hospital) attended the deceased from 12/9, 19 67, to 12/29, 19 67, that ~~I~~ (we) last saw the deceased alive on 12/29 19 67, and that in ~~my~~ (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS. [ ]	MED. DIRECTOR [X]	STAFF PHYS. [ ]	22c. DATE SIGNED 12/29/67
22d. PHYSICIAN'S NAME (Type) L. Benedict, M.D.	22e. ADDRESS Crownsville State Hosp., Maryland				

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 1/2/68	23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery	23d. LOCATION (City or Town) Baltimore	(County) (State) Maryland
24. FUNERAL DIRECTOR John A. Moran, Inc.	ADDRESS 3000 E. Balto. St. Balto	25a. REC'D BY REGISTRAR DATE JAN 3 1968	25b. REGISTRAR'S SIGNATURE Charles Judge	

VR A15 (4) 30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16407

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16398

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH
a. COUNTY: A A Co — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): D.O.A - North

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MD
b. COUNTY: A A Co
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hanover
d. STREET ADDRESS: 109 Post Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Dwight; Middle: R.; Last: Simms
4. DATE OF DEATH: Month: 12; Day: 14; Year: 1967
5. SEX: Male
6. COLOR OR RACE: N
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11-27-1949
9. AGE (In years last birthday): 18 yrs.
IF UNDER 1 YEAR: Months; Days. IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Plastic Plant
11. BIRTHPLACE (State or foreign country): Harmons, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles H. Simms
14. MOTHER'S MAIDEN NAME: Esther Mae Gaither

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give wor or dotes of service)
16. SOCIAL SECURITY NO.: 217-46-3332
17. INFORMANT: Mr. Charles H. Simms — Address: Box 109 Post Rd Hanover, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): multiple Injuries
DUE TO
(b):
DUE TO
(c):
Conditions, if any, which gove rise to immediate couse (a), stoting the underlying cause lost.
825.4
INTERVAL BETWEEN ONSET AND DEATH: Instant.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Port II of item 18.): auto accident
20c. TIME OF INJURY, Month, Day, Year: Hour a.m. p.m. 12-14 1967
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Highway
20f. (City or town): Hanover (County): A A Co (State): Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: _____ M.D.
EXAMINER'S NAME (Type): E. Linhart
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):
22. DATE SIGNED: 12-14-67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12/18/67
23c. NAME OF CEMETERY OR CREMATORY: Saints Rest Cemetery
23d. LOCATION (City or Town): Harmons (County): Anne Arundel Co. (State): Md
24. FUNERAL DIRECTOR: Herbert E. Nutter — ADDRESS: 3035 W. North Ave
25a. REC'D BY REGISTRAR — DATE: DEC 20 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16408

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16399

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH
a. COUNTY: A.A.CO. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): D.O.A – North. Arundel Hosp.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MD — b. COUNTY: A.A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hanover — 02.1
d. STREET ADDRESS: 109 Park Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Ellsworth. Middle: Leroy. Last: Simms
4. DATE OF DEATH: Month: 12 Day: 14 Year: 19 67

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	Negro	NEVER MARRIED ☑	5-10-44	23 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	U.S. Government	Harmons, Maryland	U.S.A.

13. FATHER'S NAME: Charles H. Simms
14. MOTHER'S MAIDEN NAME: Esther Mae Gaither

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
No	214-40-0383	Mr. Charles H. Simms	Box 109 Post Rd Hanover, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): multiple Injuries — INTERVAL BETWEEN ONSET AND DEATH: sudden
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
825.4

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): auto accident
20c. TIME OF INJURY Month, Day, Year: Hour a.m. p.m. 12/14 19 67
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Highway
20f. (City or town) (County) (State): AA Co MD

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑, and in my opinion death resulted from: Natural causes ☐, Accident ☑, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: [signature] M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): E. Linbach
Address (Street, city, town, or county):
22. DATE SIGNED: 12-14-67

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	12/18/67	Saints Rest Cemetery	Harmons, Anne Arundel Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Herbert E. Nutter	3035 W. North Ave	DEC 20 1967	[signature] Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (6) 6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16409

CERTIFICATE OF DEATH

16400

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ORCHARD BEACH
c. LENGTH OF STAY IN 1b: 14 YRS.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): 1015 BELUEDERE PLACE

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ANNE ARUNDEL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ORCHARD BEACH 02-1
d. STREET ADDRESS: 1015 BELUEDERE PLACE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First WILLIAM Middle JOSEPH Lost SMITH
4. DATE OF DEATH: Month DECEMBER Doy 8 Year 1967
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 14, 1912
9. AGE (In years last birthday): 55 yrs.
IF UNDER 1 YEAR: Months / Doys
IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CLERK
10b. KIND OF BUSINESS OR INDUSTRY: REVENUE SERVICE
11. BIRTHPLACE (County & State, or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: CHARLES E. SMITH
14. MOTHER'S MAIDEN NAME: MARGARET A. CURLEY
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES (If yes give war or dates of service): WORLD WAR II
16. SOCIAL SECURITY NO.: 216-01-3055
17. INFORMANT: Address: ANGELA SMITH 1015 BELUEDERE PLACE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: instantan.
DUE TO
(b): Hypertensive-arter. CVD — 4 yrs
DUE TO
(c):
Conditions, if ony, which gove rise to immediate cause (a), stating the underlying cause last.
4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this haspital) attended the deceased from Oct 1942, 19___, to Dec 7, 1967 that (I) (we) last saw the deceased alive an Dec 7, 1967, and that death accurred at 7:30 A.M, fram causes and an the date stated abave.

22a. SIGNATURE: Kennard Yaffe
M.D. ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/9/67
22c. PHYSICIAN'S NAME (Type): Kennard Yaffe, M.D.
22d. ADDRESS: 5501 Forest Park Ave, Balto Md #7

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 12-11-67
23c. NAME OF CEMETERY OR CREMATORY: BALTIMORE NATIONAL
23d. LOCATION (City or Town) (County) (State): BALTIMORE MD

24. FUNERAL DIRECTOR: C.E.O. L. Schupp & Funeral Hm. ADDRESS: Francis H. Spiller 2101 Frederick Ave. Balto Md
25a. REC'D BY REGISTRAR: DATE DEC 11 1967
25b. REGISTRAR'S SIGNATURE: M. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16410

CERTIFICATE OF DEATH

16401

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Churchton
d. STREET ADDRESS: FRANKLIN MANOR
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Constance — Middle: Helen — Last: SNYDER

4. DATE OF DEATH: Month: December — Day: 16 — Year: 19 67

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: October 3, 1901

9. AGE (In years last birthday): 66 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk

10b. KIND OF BUSINESS OR INDUSTRY: Grocery

11. BIRTHPLACE (County & State, or foreign country): GREAT BEND, PENNA

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles Herrick

14. MOTHER'S MAIDEN NAME: Viola Whitmore

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
(If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 148 20 7380

17. INFORMANT — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Metastatic carcinoma of liver — INTERVAL BETWEEN ONSET AND DEATH: 6 months
DUE TO (b): Carcinoma of bladder — 9½ yrs.
DUE TO (c):
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

1810

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan, 19 67, to Dec 16, 19 67, that (I) (we) last saw the deceased alive on Dec 15, 19 67, and that death occurred at 2:05 P.M., from causes and on the date stated above.

22a. SIGNATURE: Willard F. Smith M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 12/18/67

22c. PHYSICIAN'S NAME (Type): Willard F. Smith MD

22d. ADDRESS: Shady Side, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 12-18-67

23c. NAME OF CEMETERY OR CREMATORY: Woodfield

23d. LOCATION (City or Town) (County) (State): Galesville AACo Md

24. FUNERAL DIRECTOR: Hardesty Funeral Home — ADDRESS: Galesville, Md

25a. REC'D BY REGISTRAR DATE: DEC 26 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

x

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16411

CERTIFICATE OF DEATH

16402

1. **PLACE OF DEATH** a. COUNTY: A. A. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): W.O.A. North Arundel

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission) a. STATE: Md. b. COUNTY: A. A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Severna park 021
d. STREET ADDRESS: R. 1 Box 398
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Elijah Middle: Lost: Somerville

4. **DATE OF DEATH**: Month: 12 Day: 15 Year: 1967

5. SEX: Male

6. COLOR OR RACE: Col.

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1-3-1909

9. AGE (In years last birthday): 58 yrs.

IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Somerville

14. MOTHER'S MAIDEN NAME: Severia Jackson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give wor or dotes of service):

16. SOCIAL SECURITY NO.: 214-14-7458

17. INFORMANT: Frances Somerville Address: Severn Park

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronto Occlusion of the Heart
DUE TO (b): Pneumonia
Conditions, if ony, which gave rise to immediate couse (a), stating the underlying couse last.
DUE TO (c):
4341

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Sub. diaphragmatic Abscess

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Yeor Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 8/12, 1967, to 12/15, 1967, that (I) (we) last saw the deceased alive on 12/15 1967, and that death occurred at ____ M, from causes and on the date stated above.

22a. SIGNATURE: Albert L. Anderson — M.D. ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED:

22c. PHYSICIAN'S NAME (Type): ALBERT L. ANDERSON

22d. ADDRESS: 44 Southgate Ave Annapolis, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 12-19-67

23c. NAME OF CEMETERY OR CREMATORY: Carpenter Hill

23d. LOCATION (City or Town) (County) (State): Round Bay Md.

24. FUNERAL DIRECTOR — ADDRESS: William Reese Arnold, Md.

25a. REC'D BY REGISTRAR DATE: DEC 18 1967

25b. REGISTRAR'S SIGNATURE: Charles Yeager

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16412

CERTIFICATE OF DEATH

16403

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. **PLACE OF DEATH** a. COUNTY: A. A. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 66 College Ck. Terrace

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission) a. STATE: Md. b. COUNTY: A. A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 66 College Ck. Terrace
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Mary — Middle: — Last: Spencer

4. **DATE OF DEATH**: Month: 12 — Day: 8 — Year: 1967

5. SEX: Female
6. COLOR OR RACE: Col
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 9-19-1889
9. AGE (In years last birthday): 78 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown
MOTHER'S MAIDEN NAME: Matilda Jennings

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Albert Spencer — Address: Annapolis

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Metastic Carcinoma — INTERVAL BETWEEN ONSET AND DEATH: Months: Days: Hours: Min.: 1 month before death
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): A.C.D.P.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Oct, 1967 to Dec 8, 1967, that (I) (we) last saw the deceased alive on Dec 8, 1967, and that death occurred at 2:10 P.M., from causes and on the date stated above.

22a. SIGNATURE: Faye W. Allen — M.D. ATTENDING PHYS. ☐ MED DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/9/67
22c. PHYSICIAN'S NAME (Type): Faye W. Allen
22d. ADDRESS: 62 Cathedral St

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12-12-1967
23c. NAME OF CEMETERY OR CREMATORY: Brewer Hill
23d. LOCATION (City or Town) (County) (State): Annapolis Md.

24. FUNERAL DIRECTOR: William Reese ADDRESS: Annapolis Md.
25a. REC'D BY REGISTRAR DATE: DEC 13 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Yingst

Item 21 Film 396 12-22-

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16413

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16404

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel County — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town):
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): North Arundel Hospital

2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bowie
d. STREET ADDRESS: Box 402 Race Track Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First WILLIAM Middle F Lost STEPPER

4. DATE OF DEATH: Month December Doy 12 Year 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 25, 1930

9. AGE (In yeors lost birthdoy): 37 yrs.
IF UNDER 1 YEAR: Months / Doys
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ELECTRICIAN

10b. KIND OF BUSINESS OR INDUSTRY: GEN BLDG TRADES

11. BIRTHPLACE (State or foreign country): WASHINGTON, D C

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: BENJ. FRANKLIN STEPPER

14. MOTHER'S MAIDEN NAME: ETHEL ROGERS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: PATRICIA ANN STEPPER Address: SAME AS #2.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Drowning
DUE TO (b):
DUE TO (c):
Conditions, if ony, which gove rise to immediote couse (o), stoting the underlying couse last.
8244
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o)

19. WAS AUTOPSY PERFORMED? YES ☑ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
Subject apparently drove into bridge and went into the wat

20c. TIME OF INJURY Month, Doy, Year Hour XXX: 7:00 p.m. 12 12 '67

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.): Water

20f. (City or town) A. A. (County) (State) M.D.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, ond in my opinion deoth resulted from: Naturol causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☒

ACTUAL SIGNATURE: Edward F. Wilson M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐

EXAMINER'S NAME (Type): Edward F. Wilson, M.D.

Address (Street, city, town, or county):

22. DATE SIGNED: December 13, 1967

23a. BURIAL, CREMATION, REMOVAL (Specify): Buried

23b. DATE THEREOF: 12/15/67

23c. NAME OF CEMETERY OR CREMATORY: BALTIMORE NATIONAL CEM

23d. LOCATION (City or Town) (County) (State): BALTIMORE, Md.

24. FUNERAL DIRECTOR: [illegible] ADDRESS: 550 WASH'N BLVD LAUREL, MD

25a. REC'D BY REGISTRAR DATE: DEC 15 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 2M3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health priar to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 6M 1/67

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

16414

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16405

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): D.O.A.Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 9 Monument Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First KERNELL — Middle NMN — Last STEVENS

4. DATE OF DEATH: Month Dec. — Day 23 — Year 19 67

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 4,1910

9. AGE (In years last birthday): 57 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired U.S.Naval Academy-Midshipmens

10b. KIND OF BUSINESS OR INDUSTRY: STORE

11. BIRTHPLACE (State or foreign country): Annapolis, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George NMN Stevens

14. MOTHER'S MAIDEN NAME: Lela NMN Porter

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes give war or dates of service): W.W.II

16. SOCIAL SECURITY NO.: 214-05-1870

17. INFORMANT: Agnes J. Stevens — Address: 9 Monument St. Anna. Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac Arrest
DUE TO (b): Arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH: Sudden

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: E.G. Linhardt M.D.

EXAMINER'S NAME (Type): E.G.LINHARDT

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county)

22. DATE SIGNED: 12-23-67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Dec. 26-67

23c. NAME OF CEMETERY OR CREMATORY: St. Mary's

23d. LOCATION (City or Town) (County) (State): Annapolis, Maryland

24. FUNERAL DIRECTOR — ADDRESS: C.E.Hicks 111 Annapolis, Md.

25a. REC'D BY REGISTRAR DATE: JAN 2 1968

25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16415

CERTIFICATE OF DEATH

16406

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 14 Severn Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary Jones — Middle: Louise — Last: TARR

4. DATE OF DEATH: Month: December — Day: 21 — Year: 19 67

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: October 9, 1881
9. AGE (In years last birthday): 86 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOMEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: HOME
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: HENRY C. JONES
14. MOTHER'S MAIDEN NAME: MARY SKINNER LEGG

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes give war or dates of service): —
16. SOCIAL SECURITY NO.: 218 10 6946
17. INFORMANT: MRS. LOUISE BOETTCHER — Address: #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma, head of pancreas
DUE TO
157 X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):
INTERVAL BETWEEN ONSET AND DEATH: Unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from _____, 1962, to 12/21, 1967, that (I) (we) last saw the deceased alive on 12/21 1967, and that death occurred at 8:15 P.M. from causes and on the date stated above.

22a. SIGNATURE: Richard L. Hochman
M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/22/67
22c. PHYSICIAN'S NAME (Type): Richard I. Hochman, MD
22d. ADDRESS: 16 Murray Avenue, Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12-26-67
23c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet
23d. LOCATION (City or Town) (County) (State): Balto MD.

24. FUNERAL DIRECTOR: John M. Taylor & Sons — ADDRESS: Annapolis, Md.
25c. RECD BY REGISTRAR DATE: DEC 27 1967
25b. REGISTRAR'S SIGNATURE: Beverly Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16416

16407

1. PLACE OF DEATH
a. COUNTY: A. A. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): A. A. General

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md.
b. COUNTY: A. A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 10 College Creek
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary — Middle: Grace T. — Last: Thomas

4. DATE OF DEATH: Month: 12 — Day: 10 — Year: 1967

5. SEX: Female

6. COLOR OR RACE: Col

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 5-1-1910

9. AGE (In years last birthday): 57 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Randolph Thomas

14. MOTHER'S MAIDEN NAME: Rosie Randall

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service):

16. SOCIAL SECURITY NO.: 213-16-4008

17. INFORMANT: Rachel Parker — Address: 10 College Ck.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Coronary Thrombosis due to Arteriosclerotic — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
(b): Hypertensive Cardio Vascular Disease — 1 year
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Doy, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from November, 1967, to Dec. 10, 1967, that (I) (we) last saw the deceased alive on Dec. 10 1967, and that death occurred at 2:30 PM, from causes and on the date stated above.

22a. SIGNATURE: R. L. Richardson M.D.
M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12-12-67
22c. PHYSICIAN'S NAME (Type): R. L. Richardson, M.D.
22d. ADDRESS: 110 Clay St., Annapolis, Md., 21401

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12-13-67
23c. NAME OF CEMETERY OR CREMATORY: Hopes Chapel
23d. LOCATION (City or Town) (County) (State): Edgewater Md.

24. FUNERAL DIRECTOR: William Reese — ADDRESS: Anna. Md.
25a. REC'D BY REGISTRAR DATE: DEC 13 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16417

CERTIFICATE OF DEATH

16408

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 4 Bricin St.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Alvin — Middle: Wesley — Last: TROTT

4. DATE OF DEATH: Month: December — Day: 6 — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 4, 1926

9. AGE (In years last birthday): 41 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Plasterer

10b. KIND OF BUSINESS OR INDUSTRY: Construction

11. BIRTHPLACE (County & State, or foreign country): Anne Arudel, Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: Alvin J. Trott

14. MOTHER'S MAIDEN NAME: Anna Clark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): (If yes give wor ar dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Joyce Trott — Address: #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Metastatic (to Abd. cavity, liver, retroperitoneal space) — INTERVAL BETWEEN ONSET AND DEATH: 3 mos
DUE TO
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
(b):
DUE TO
(c): Oat Cell Carcinoma of Lt. Lung — 1½ years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) ~~(An Hospital)~~ attended the deceased from July, 1966 to Dec. 5, 1967 that (I) ~~(We)~~ last saw the deceased alive an Dec. 5, 1967, and that death occurred at 12:10 AM, from causes and on the date stated above.

22a. SIGNATURE: Peter F. Verkouw M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: Dec. 6, 67

22c. PHYSICIAN'S NAME (Type): Peter F. Verkous, M.D.

22d. ADDRESS: 1407 Forest Drive, Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 12-9-67

23c. NAME OF CEMETERY OR CREMATORY: Hillcrest

23d. LOCATION (City or Town) (County) (State): Annapolis A.A. MD.

24. FUNERAL DIRECTOR: John M. Taylor Sons — ADDRESS: Annapolis, Md.

25a. REC'D BY REGISTRAR DATE: DEC 8 1967

25b. REGISTRAR'S SIGNATURE: Charles Juzze.

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16418

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16409

1. PLACE OF DEATH
a. COUNTY: A. A. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): A. A. General

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md.
b. COUNTY: A. A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 29 parole Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Alice — Middle: R. — Last: Turner

4. DATE OF DEATH: Month: 12 — Day: 11 — Year: 1967

5. SEX: Female

6. COLOR OR RACE: Col.

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 5-3-1919

9. AGE (In years last birthday): 48 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Jessie Parker

14. MOTHER'S MAIDEN NAME: Georgana Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 214242922

17. INFORMANT: Richard H. Turner — Address: Annapolis Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Multiple Injuries — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO
(b):
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Auto accident

20c. TIME OF INJURY Month, Day, Year: Hour a.m. p.m. 12/11 1967

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Highway

20f. (City or town): Alta — (County): — (State): MD

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: E Linhardt — M.D.

EXAMINER'S NAME (Type): E. Linhardt

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐

Address (Street, city, town, or county):

22. DATE SIGNED: 12/11/67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 12.16.1967

23c. NAME OF CEMETERY OR CREMATORY: Pine Lawn

23d. LOCATION (City or Town): Annapolis — (County): — (State): Md.

24. FUNERAL DIRECTOR: William Reese — ADDRESS: Anna. Md.

25a. REC'D BY REGISTRAR DATE: DEC 13 1967

25b. REGISTRAR'S SIGNATURE:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16419

CERTIFICATE OF DEATH

16410

1. **PLACE OF DEATH**
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville md
c. LENGTH OF STAY IN 1b: @5 months.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): @Crownsville STATE Hosp. Md.

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ARNOLD Md.
d. STREET ADDRESS: 307 HASKELL Dr.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. **NAME OF DECEASED** (Type or print): First HARRY — Middle D. — Last VIERLING

4. **DATE OF DEATH**: Month 12 — Day 2 — Year 1967

5. SEX: male

6. COLOR OR RACE: Cau.

7. MARRIED ☑ — NEVER MARRIED ☐ — WIDOWED ☐ — DIVORCED ☐

8. DATE OF BIRTH: 8/9/05

9. AGE (In years last birthday): 62 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ENG. WRITER

10b. KIND OF BUSINESS OR INDUSTRY: WESTING HOUSE

11. BIRTHPLACE (County & State, or foreign country): N.Y.C. N.Y.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: HARRY S. VIERLING

14. MOTHER'S MAIDEN NAME: Mc INTOSH

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO. (If yes give wor or dotes of service)

16. SOCIAL SECURITY NO.: 084-09-5064

17. **INFORMANT**: MRS DOROTHY S. VIERLING (WIFE) — Address: ARNOLD MD. 307 HASKELL DR.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonia — INTERVAL BETWEEN ONSET AND DEATH
DUE TO: CHRONIC PULMONARY DISEASE (EMPHYSEMA)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): — DUE TO
(c): ALZHEIMERS DIS. & CEREBRAL ATROPHY.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 7/21, 1967, to 12/2, 1967, that (I) (we) last saw the deceased alive on 12/2 1967, and that death occurred at 6 PM, from causes and on the date stated above.

22a. SIGNATURE: Garrett M. Mays M.D. — ATTENDING PHYS. ☐ — MED. DIRECTOR ☐ — STAFF PHYS. ☑

22b. DATE SIGNED: 12/2/67

22c. PHYSICIAN'S NAME (Type): GARRETT M. MAYS MD.

22d. ADDRESS: CROWNSVILLE STATE HOSP. Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5 Dec. 67

23c. NAME OF CEMETERY OR CREMATORY: Glen Haven Memorial

23d. LOCATION (City or Town) (County) (State): Glen Burnie, Maryland

24. FUNERAL DIRECTOR — ADDRESS: Kirkley Funeral Home, Glen Burnie, Md.

25a. REC'D BY REGISTRAR — DATE: DEC 5 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

16420 16411

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
William	Henry	Washington	12	27	67	5:00 M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.
Male	Negro	1/23/97	70 YRS.				

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED XX DIVORCED ☐	9. COUNTY OF DEATH
Maryland	USA		Anne Arundel Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Crownsville	Crownsville State Hospital	~~Stevedore~~ Unemployed	~~Dock~~

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	A A	Annapolis	YES X NO ☐	8 cornhill Street 02.1

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
William	Henry	Washington	Annie ?	NMN	Nichols

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	If yes, give war or dates of service	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
Yes	WWI	218-10-4688	Hospital Records,	Crownsville State Hospital

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Pneumonia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

493X

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Chronic Brain Syndrome, Diabetes Mellitus

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO X	

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that ~~(I)~~ (this hospital) attended the deceased from 9/9/59, to 12/27/67, that ~~(I)~~ (we) last saw the deceased alive on 12/27/67, and that in ~~(my)~~ (our) opinion death occurred on the date and hour and from the causes stated above, ~~(I)~~ (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
[signature]		☐	X	☐	12/28/67

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
L. Benedict, M.D.	Crownsville State Hospital, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	1-2-68	Brewer Hill	Annapolis A.A. Co Md

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Charles E. Hicks Chas Hicks & Son	Annapolis, Md 43 Dr. V. St	JAN 5 1968	Charles Judge

VR A15 (4) 30M REV. 11-68

4 1

16421

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items #13 & 14 Film #6206 12/27/67 ph

16412

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 25M 1/67

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie MD
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): North Arundel Conv. Cent. 313 Hosp. Dr.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ferndale
d. STREET ADDRESS: 104 Gordon Lane 21061
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Daisy Middle: M. Last: Weigand

4. DATE OF DEATH: Month: Dec Day: 19 Year: 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: MAY 17, 1887

9. AGE (In years last birthday): 80 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Maryland (Baltimore)

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ? George Wholey

14. MOTHER'S MAIDEN NAME: ? Katherine Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs Helen Walters 104 Gordon Lane 21061

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Left Ventricular failure — INTERVAL BETWEEN ONSET AND DEATH: hours
DUE TO
(b): Acute Myocardial Infarction — hours.
DUE TO
(c): Congestive heart failure — days.
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Generalized arteriosclerosis - Fracture R-hip.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☒ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.): Patient fell in her own livingroom

20c. TIME OF INJURY Hour: a.m. p.m. Month, Day, Yeor: Nov 2 1967

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town) (County) (State): Ferndale

21. I certify that (I) (this hospital) attended the deceased from 12/8, 1967 to 12/19, 1967, that (I) (we) last saw the deceased alive an Dec 14 1967, and that death occurred at 9 AM from causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 12/19/67

22c. PHYSICIAN'S NAME (Type): MAX C FRANK MD

22d. ADDRESS: 725 SC Ritchie Hwy - Glen Burnie MD 21061

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 12/23/67

23c. NAME OF CEMETERY OR CREMATORY: Holy Cross Cemetery

23d. LOCATION (City or Town) (County) (State): Anne Arundel Co. Md.

24. FUNERAL DIRECTOR: MCF.H. 737 Catapsco [illegible] ADDRESS

25a. REC'D BY REGISTRAR DATE: DEC 22 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Yeager

Buried 12/23/67 Holy Cross Cemetery Anne Arundel Co. Md.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

16422 16413

1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PATAPSCO PARK
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 221 SHENANDOAH AVENUE

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY A.A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PATAPSCO PARK 02.1
d. STREET ADDRESS 221 SHENANDOAH AVE.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First ROBERT Middle JAMES Last WHEELER
4. DATE OF DEATH Month DEC. Day 13, Year 1967
5. SEX MALE
6. COLOR OR RACE COLORED
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH 10-8-1879
9. AGE (In years last birthday) 88 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) COOK
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (County & State, or foreign country) BALTIMORE, MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME JAMES WHEELER
14. MOTHER'S MAIDEN NAME ELEENORA?
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) NO (If yes give war or dates of service)
16. SOCIAL SECURITY NO. 217-05-7091
17. INFORMANT Address FLORENCE GRAY - 77-79 COLUMBIA ST., N. YI

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardio-Vascular Disease
443X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1 Jan, 1964, to 13 Dec, 1967, that (I) ~~(we)~~ last saw the deceased alive on 2 Dec 1967, and that death occurred at 11:00 AM, from the causes and on the date stated above.

22a. SIGNATURE Renold B. Lighston Jr. M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED 15 Dec 67
22c. PHYSICIAN'S NAME (Type) RENOLD B. LIGHSTON, M. D.
22d. ADDRESS 501 CHERRY HILL RD., BALTO., MD.

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
23b. DATE THEREOF 12-16-67
23c. NAME OF CEMETERY OR CREMATORY MT. CALVARY
23d. LOCATION (City, town or county) (State) BALTIMORE, MARYLAND

24. FUNERAL DIRECTOR Charles L. Law
ADDRESS 802 MADISON AVE.
25a. REC'D BY REGISTRAR DATE DEC 20 1967
25b. REGISTRAR'S SIGNATURE Charles Yingling

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 415 (4) 20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16423

CERTIFICATE OF DEATH

16414

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md/N/A — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): N/A Severna Park
d. STREET ADDRESS: Box 4X N/A Jones Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Baby — Middle: Boy — Last: White
4. DATE OF DEATH: Month: Dec — Day: 10 — Year: 1967
5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 12/10/67
9. AGE (In years last birthday) yrs.: IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours 11 / Min. 45

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant
10b. KIND OF BUSINESS OR INDUSTRY: N/A
11. BIRTHPLACE (County & State, or foreign country): Anne Arundel, Md.
12. CITIZEN OF WHAT COUNTRY: USA.

13. FATHER'S NAME: Milton Summerville
14. MOTHER'S MAIDEN NAME: Glossie White

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Address: Glossie White Severna Park Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Massive pulmonal atelectasis — INTERVAL BETWEEN ONSET AND DEATH: Life
DUE TO (b): Prematurity — Life
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
7625

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Dec. 10, 1967 to Dec. 16, 1967, that (I) (we) last saw the deceased alive on Dec 14 1967, and that death occurred at 10.25 A.M., from causes and on the date stated above.

22a. SIGNATURE: Richard C. Leary M.D. — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/11/67
22c. PHYSICIAN'S NAME (Type): Richard C. Leary, M.D.
22d. ADDRESS: South River Med Cntr. Edgewater, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 12/15/67
23c. NAME OF CEMETERY OR CREMATORY: Carpenter Hill
23d. LOCATION (City or Town) (County) (State): Severna Park A.A.Co Md

24. FUNERAL DIRECTOR: Johnson's Funeral Home ADDRESS: Ann, Md
25a. REC'D BY REGISTRAR DATE: DEC 22 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16424

CERTIFICATE OF DEATH

16415

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corparate limits, write RURAL and give nearest tawn): Glen Burnie
c. LENGTH OF STAY IN 1b: 10 hours
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): North Arundel Hospital

2. USUAL RESIDENCE (Where deceased lived, if institutian: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corparate limits, write RURAL and give nearest tawn): Pasadena, Md.
d. STREET ADDRESS: Forest Dr. Box 524 Rt.10
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type ar print): First: Mildred — Middle: E M. — Last: White
4. DATE OF DEATH: Month: 12 — Day: 21 — Year: 19 67

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Haurs / Min.
Female	White	NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	6-26-09	58 yrs.		

10a. USUAL OCCUPATION (Give kind af wark dane during mast af warking life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (Caunty & State, ar fareign cauntry)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Own Home	Frederick, Maryland	USA

13. FATHER'S NAME: William Anderson
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na, ar unknawn) (If yes give war ar dates af service)	16. SOCIAL SECURITY NO.	17. INFORMANT — Address
		Mrs. Gladys Rowens, Pasadena, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter anly ane cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 443 X
DUE TO
(b):
DUE TO
(c):
Canditians, if any, which gave rise ta immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature af injury in Part I ar Part II af item 18.)
20c. TIME OF INJURY Manth, Day, Year Haur a.m. p.m. 19
20d. INJURY OCCURRED While at wark ☐ Nat While at wark ☐
20e. PLACE OF INJURY (Hame, farm, factary, street, affice bldg., etc.)
20f. (City ar tawn) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 12-21, 1967, ta 12-21, 1967, that (I) (we) last saw the deceased alive an 12-21 19 67, and that death accurred at 10:10 am causes and an the date stated above.

22a. SIGNATURE: Alejandro Montoya — ATTENDING PHYS. M.D. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/21/67
22c. PHYSICIAN'S NAME (Type): Alejandro Montoya, M.D.
22d. ADDRESS: 707 Old Annapolis Rd., G.B. 21061

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Tawn) (County) (State)
Burial	23 Dec. 67	Glen Haven Memorial	Glen Burnie, Md.

24. FUNERAL DIRECTOR — ADDRESS: Kirkley's Funeral Home, Glen Burnie
25a. REC'D BY REGISTRAR DATE: DEC 27 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

2

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

16425

16416

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, ar removal, and in any event, within 72 hours after death.

VR A15 (M)
30M REV. 1968

1. DECEASED-NAME (Type ar print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
Dennis	Wilson		12	12	1967	M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.
Male	Colored	10-3-1895	72 YRS.				

7a. BIRTHPLACE (State ar foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH
A. Arnd	U.S.A.		Anne Arundel Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If nat in haspital give street address)	12a. USUAL OCCUPATION (Kind af wark dane during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Annapolis	A. A. General	Retired	

13a. USUAL RESIDENCE (Where deceased lived, if institutian, Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Md.	A. A.	Annapolis	YES ☒ NO ☐	102 South Sts

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Ollie		Wilson	Mary		Wilson

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, ar unknawn) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
		Maggie Foote	102 South Sts.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter anly one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiac arrest

DUE TO, OR AS A CONSEQUENCE OF (b) Cardiac failure

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditians, if any, which gave rise ta immediate cause (a), stating the underlying cause last.

4330

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. (If either, natify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Manth Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 ar Part 2, Item 18.)

21d. INJURY OCCURRED While at wark ☐ Nat while at wark ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street ar R.F.D. Na.	City ar Tawn	County	State
		4 4 5 [illegible]	12-14-67		

22a. **I certify** that (I) (this hospital) attended the deceased from [illegible], 19___, to 12-14-67, 19___, that (I) (we) last saw the deceased alive an 12-12-67 19___, and that in (my) (our) apinion death occurred on the date and haur and from the couses stated obave, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
[signature]		☒	☐	☐	12-14-67

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
A. T. ALLEN	62 Adelaide

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City ar Tawn) (County) (State)
Burial	12-16-1967	Fontleroy	Annapolis Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
William Reese #	Anna. Md.	DEC 15 1967	Charles Jones

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

16426 — 16417

1 (M)

1. PLACE OF DEATH
a. COUNTY: Anne ARundel — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Laurel
c. LENGTH OF STAY IN 1b: 12 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Children's Center Hospital

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington, D. C.
d. STREET ADDRESS: 233- 12th Place, N. E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John — Middle — Last: Winebrenner

4. DATE OF DEATH: Month: December — Day: 1 — Year: 1967

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	NEVER MARRIED ☒	9-15-48	19 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Institutionalized	--------	Washington, D. C.	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John P. Winebrenner	Annie Mae Winebrenner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
No		Children's Center Hospital, Laurel, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e): ASPIRATION — INTERVAL BETWEEN ONSET AND DEATH: 10 Min

3255

Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.

DUE TO (b): MENTAL RETARDATION

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(e): EPILEPSY

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

2

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from February 4, 1955, to December 1, 1967 that (I) (we) last saw the deceased alive on November 30 1967, and that death occured at 10:00 am from the causes and on the date stated above.

22a. SIGNATURE: William Frank M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: Dec. 1, 1967

22c. PHYSICIAN'S NAME (Type): WILLIAM FRANK, M. D.

22d. ADDRESS: Children's Center Hospital, Laurel, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
BP	12-5-67	Children's Center	Laurel, Md. A.A. Co.

24. FUNERAL DIRECTOR'S SIGNATURE: William A. Mahoney — ADDRESS: Laurel Md.

25a. REC'D BY REGISTRAR DATE: DEC 8 1967 — 25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, and by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

16427 — 16418

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b: 14 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Rte. 2, Box 451, Point Pleasant

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
d. STREET ADDRESS: Rte. 2, Box 451, Point Pleasant
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Charles — Middle: N. — Last: Worthington

4. DATE OF DEATH: Month: December — Day: 8, — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: 8 May 1877

9. AGE (In years last birthday): 90 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter

10b. KIND OF BUSINESS OR INDUSTRY: Retired

11. BIRTHPLACE (County & State, or foreign country): Howard County, Md.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Joseph E. Worthington

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.: 217-01-1999

17. INFORMANT Address: Mrs. Harry Christopher, same as 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH:
443X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Hypertensive Cardiovascular disease
DUE TO (c): Generalized arteriosclerosis.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year / Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4/29/64, 19__, to 12/7, 1967, that (I) (we) last saw the deceased alive on 12/8 1967, and that death occurred at 3:54 AM, from the causes and on the date stated above.

22a. SIGNATURE: William S. Linsao M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): G. S. Linsao, M. D.

22d. ADDRESS: 7308 Furnace Branch Rd., Glen Burnie, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 11 Dec. 67

23c. NAME OF CEMETERY OR CREMATORY: Glen Haven Memorial

23d. LOCATION (City, town or county) (State): Glen Burnie, Maryland

24. FUNERAL DIRECTOR ADDRESS: Kirkley Funeral Home, Glen Burnie, Md.

25a. REC'D BY REGISTRAR DATE: DEC 12 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

16428

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

16419

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. **PLACE OF DEATH**
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sherwood Forest 02
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Clarence — Middle: Martin — Last: WRIGHT

4. **DATE OF DEATH**: Month: December — Day: 18 — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 3, 1905

9. AGE (In years last birthday): 62 yrs.
IF UNDER 1 YEAR: Months: — Days:
IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Editor & Writer

10b. KIND OF BUSINESS OR INDUSTRY: News Letters

11. BIRTHPLACE (County & State, or foreign country): Texas

12. CITIZEN OF WHAT COUNTRY? U. S.A.

13. FATHER'S NAME: CLARENCE MARTIN

14. MOTHER'S MAIDEN NAME: EVELYN MATHEWS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. **INFORMANT**: ROSA DEE WRIGHT -wife- Address: SAME AS #2

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary Emphysema
DUE TO
5020
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Bronchitis
DUE TO
(c):
INTERVAL BETWEEN ONSET AND DEATH: Years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Sept, 1966, to 12-18, 1967, that (I) (we) last saw the deceased alive on 12-18, 19 67, and that death occurred at 12:45 P.M. from causes and on the date stated above.

22a. SIGNATURE: Frank M. Shipley — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 12-18-67

22c. PHYSICIAN'S NAME (Type): F. M. SHIPLEY

22d. ADDRESS: Annapolis, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): CREMATION

23b. DATE THEREOF: 12/22/67

23c. NAME OF CEMETERY OR CREMATORY: CEDAR HILL CREMATORY

23d. LOCATION (City or Town) (County) (State): SUITLAND, PRINCE GEORGE, MD.

24. FUNERAL DIRECTOR — ADDRESS: JOSEPH GAWLER'S SONS 5130 Wisc, Ave. N.W. Wash. DC

25a. REC'D BY REGISTRAR — DATE: DEC 28 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Juaga

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16429

CERTIFICATE OF DEATH

16420

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH a. COUNTY: Anne Arundel — MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institutian: Residence before admission) a. STATE: Maryland — b. COUNTY: Anne Arundel
b. CITY OR TOWN (If autside corporote limits, write RURAL and give nearest tawn): Annapolis — c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town): Annapolis 021
d. NAME OF HOSPITAL OR INSTITUTION (If nat in hospital, give street address): Anne Arundel General Hospital	d. STREET ADDRESS: 162 O'Bery Court — e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First	Middle	Lost	4. DATE OF DEATH Manth	Day	Year
Phillip	Isiah	WRIGHT	December	25	19 67

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In yeors last birthdoy)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	Negro		Jamuary 20, 1920	47 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Helper	U. S. Na. Acad.	Maryland	U. S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
William E. Wright	Alverta Johnson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown)	(If yes give wor or dotes of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
No			Martha E. Wright	Annp. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter anly one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Metastatic Carcinoma — INTERVAL BETWEEN ONSET AND DEATH: 6 mths

DUE TO (b): Carcinoma of Esophagus

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

150 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Yeor Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)

21. **I certify** that (I) (this haspital) attended the deceased from 7 DEC, 1967, to 25 DEC, 1967, that (I) (we) last saw the deceased alive on 25 DEC 1967, and that death accurred at 2:30 P.M. from causes and an the date stated abave.

22a. SIGNATURE	ATTENDING PHYS. ☒	MED. DIRECTOR ☐	STAFF PHYS. ☐	22b. DATE SIGNED
Edward H. Beese				12-26-67

22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	12/29/67	Pine Lawn	Annp. Md. A.A. Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
William Reese, Jr.	Annp. Md.	DEC 27 1967	Wilmalee Jordan

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16430 16421

1. PLACE OF DEATH
a. COUNTY: A.A. Co — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis MD
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): A. A. Gen Hosp

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MD
b. COUNTY: AA
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): R+1 Box 493 02-1
d. STREET ADDRESS: Arnold Md
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Disak — Middle: Ilmari — Last: Yrttimaa
4. DATE OF DEATH: Month: 12 — Day: 2 — Year: 67 — 19
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 10-28-91
9. AGE (In years last birthday): 76 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Tavern Owner
10b. KIND OF BUSINESS OR INDUSTRY: Retired
11. BIRTHPLACE (County & State, or foreign country): Finland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: XXXXXXX Unknown Frans Disak Yrttimaa
14. MOTHER'S MAIDEN NAME: XXXXXXX Unknown Hedvik Serafi Yrttimaa
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.: & --
17. INFORMANT: Raymond E. Yrttimaa — Address: Rt. 1, Box 493 Arnold, Md. Mill Creed Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac arrest - Coughed — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b): Acute myocardial infarction
DUE TO (c): A C V D
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4201
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1960, 19 27, to 1967, 19__, that (I) (we) last saw the deceased alive on 12-1-67 19__, and that death occurred at 10 A.M.; from causes and on the date stated above.

22a. SIGNATURE: Robert R. Hahn M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12-2-67.
22c. PHYSICIAN'S NAME (Type): Robert R. HAHN
22d. ADDRESS: P.O. Box 73 Severna Park

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12/6/'67
23c. NAME OF CEMETERY OR CREMATORY: Oak Lawn Cemetery
23d. LOCATION (City or Town) (County) (State): Baltimore, Maryland
24. FUNERAL DIRECTOR — ADDRESS: John A. Moran, Inc. 3000 E. Baltimore St.
25a. REC'D BY REGISTRAR — DATE: DEC 6 1967
25b. REGISTRAR'S SIGNATURE: Jeanne Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16431 16422

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie Md.
c. LENGTH OF STAY IN 1b: yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): N. Arundel Hosp.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sanders Park, Pasadena, Md.
d. STREET ADDRESS: Box 111 A Rt. 11, Pasadena Md.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First FREDERICK Middle E. Last ZERRLAUT
4. DATE OF DEATH: Month 12 Day 16 Year 1967
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☑
8. DATE OF BIRTH: 8/8/1908
9. AGE (In years last birthday): 59 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Handyman
10b. KIND OF BUSINESS OR INDUSTRY: Private Homes
11. BIRTHPLACE (County & State, or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Frederick Zerrlaut
14. MOTHER'S MAIDEN NAME: Etta ?
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 212-10-2386
17. INFORMANT: Mrs Mary E. Montgomery Box 111A Rt 11 Address Sanders Park

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CORONARY THROMBOSIS — INTERVAL BETWEEN ONSET AND DEATH: 48 hrs.
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)
4201
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 12/15, 1967 to 12/16, 1967 that (I) (we) last saw the deceased alive on 12/15 1967, and that death occurred at 9:15 AM, from causes and on the date stated above.

22a. SIGNATURE: J. Brady Smith — M.D. ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/16/67
22c. PHYSICIAN'S NAME (Type): J. BRADY SMITH
22d. ADDRESS: 8471 Ft. Smallwood Rd. A.A., MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12/19/67
23c. NAME OF CEMETERY OR CREMATORY: Glen Haven Cem.
23d. LOCATION (City or Town) (County) (State): Glen Burnie Md.
24. FUNERAL DIRECTOR: John J. Cowen & Son Inc. ADDRESS: 9 Hollins St. 21 Md.
25a. REC'D BY REGISTRAR DATE: DEC 18 1967
25b. REGISTRAR'S SIGNATURE: Charles Jones